



The Modern Hospital

MARCH 1952 *Portfolio on hospital building (tuberculosis, psychiatric, convalescent and rehabilitation units in the general hospital) • Should hospital buyers accept gifts from suppliers? (page 92) Making it easier for child patients • Maintaining kitchen equipment*

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New Primary School, Deerfield, Ill. Kindergarten room is one of eight classrooms grouped in the wing at the left in exterior photo. Gym-cafeteria unit is in the center, the administrative wing on the right. Exterior finish is colonial red brick with Indiana Limestone trim.

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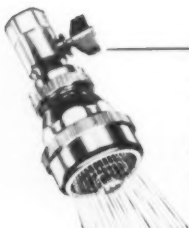
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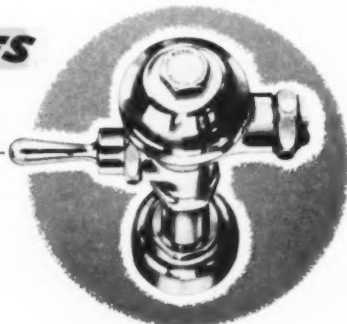
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The Modern Hospital

MARCH 1952

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AMONG THE AUTHORS

Dr. A. Chesmore Eastlake Jr. is assistant professor of medicine at the University of Oregon Medical School, Portland, Ore., where he is also assistant director of the project in constitutional medicine. The son of a Denver internist, Dr. Eastlake went to the University of Denver and took his medical degree at the University of Colorado. Following internship, he served as assistant pathologist at Kings County Hospital, Brooklyn, N.Y., then became a resident staff member in tuberculosis at the San Francisco Hospital and assistant in medicine at the University of California. Before returning to the West Coast, he served for four years as assistant director of inhalational therapy at New York's Presbyterian Hospital and assistant in medicine at Columbia University College of Physicians and Surgeons. Author of numerous articles in the field of chest diseases, Dr. Eastlake has written for *The MODERN HOSPITAL* a description of a new "lung immobilizer." The article appears on page 106.



Dr. A. C. Eastlake Jr.

Louis S. Reed Ph.D., author of the article on hospital construction in the United States, on page 72, is a medical economist. Trained as an economist at Amherst College and Columbia University, after some years of university teaching, he first entered the health field as a member of the research staff of the Committee on the Costs of Medical Care. After an interlude of other work, he joined the Division of Health Studies of the Social Security Board, and later the U. S. Public Health Service where he has served with the Division of Public Health Methods and the Division of Hospital Facilities. He is now chief of the medical economics branch of the Division of Medical and Hospital Resources.



Louis S. Reed

Peter N. Jensen, whose plan for a TB nursing unit appears on page 55 of this issue, is with the Division of Hospital Facilities, U. S. Public Health Service, where he is specializing in tuberculosis hospital planning. Mr. Jensen studied at the Beaux Arts Institute of Design and for a number of years was associated with some of the better known architectural firms in New York City. While with Walker and Gillette, he had charge of planning for the conversion of Westchester County Almshouse to what is now Grasslands Hospital.



Peter N. Jensen

Cecilia M. Knox is nurse consultant in the Division of Medical and Hospital Resources, U. S. Public Health Service. A graduate of St. Francis Hospital School of Nursing, Peoria, Ill., and the University of Chicago, Miss Knox did graduate work at both the University of Chicago and the University of Massachusetts. Positions she held during her civilian nursing experience were mainly in nursing education and nursing service. Before entering the U. S. Public Health Service she was director of the school of nursing and nursing service for five years at Boston City Hospital, Boston. In addition to articles for the professional magazines she is the author of a pediatrics textbook for nurses. Miss Knox is co-author with Peter Jensen of the plan for a tuberculosis unit appearing on page 55 of this issue.



Cecilia M. Knox

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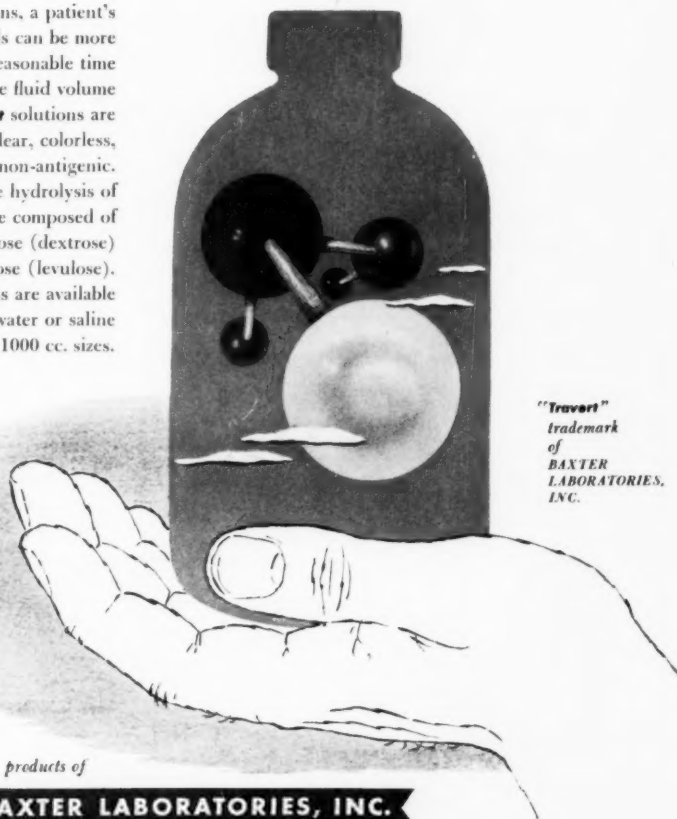
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Reader Opinion

Federal Aid? Yes!

Sirs:

The editorial, "Everybody Won," in the November issue of *The MODERN HOSPITAL*, makes sense. There is no basis or evidence that tends to support the argument that federal aid to schools of nursing will bring socialism. At

least none of the arguments so far advanced offer any logical support of the statements discussing the subject. It seems to me that those who support the idea that federal aid will bring socialism are basing their statements on fear instead of fact. If those organizations in the field of health stood idly

by and rested the entire matter with the government—accepting whatever plan the government wanted with a mere "amen"—I would be inclined to believe that federal aid might bring socialism in this particular phase of hospital responsibility. However, it is not the intention—as has been ably demonstrated—of our volunteer health interests to play a passive rôle. The thing that really matters is the character of whatever bill may finally become law. While I have little faith in the side of government I certainly have such complete confidence in those who represent us that I believe a "fair" bill will emerge.

It seems to me that schools of nursing have every right and reason to request and receive federal assistance inasmuch as government needs for graduate nurses are supplied entirely by existing schools of nursing. It is the only source of supply since the government does not conduct any such schools; it is spared this expense. Why then should it not make a fair contribution toward the support of them?

ACCUSED OF SOCIALISM

We must remember that accusations of "socialism" and "federal control" came from many quarters regarding Public Law 725 (Hill-Burton) which was designed to aid in the building of hospital facilities. Many could not be convinced then that they were wrong. Even now some of the diehards believe that government can dictate policies regarding the operation of those hospitals that received federal money under Federal Law 725.

It is natural that differences of opinion will arise on any issue that might confront hospitals, at least during the discussion period. I believe in working with the government in any matter of concern to hospitals and the professions they represent, fully realizing that we must be ready and willing to exert every influence at our command to evolve a sane and sensible solution of issues so that the American way of life will not be endangered. Unfortunately, we too often permit our emotions, mixed with fear, suspicion and prejudice, to black out completely all elements of logic and reason. Our hope is

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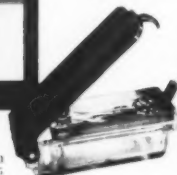
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in holding a solid united front and to fight for our rights. If we do this I believe we can cooperate *with* government control or socialism in our American hospital system. If we fail in such an objective we should then blame ourselves and not government. Both the acts and philosophy that have been and are continuing to be so positively demonstrated on the part of government should place us, and the country at large, on guard. Confiscation of public rights and attempts at confiscation—closely resembling the things that hap-

pen behind the Iron Curtain—should be sufficient reason for a solid front for any organization that hopes to preserve its inalienable rights.

Sure, taxes are higher than they should be because of government's fantastic extravagance. Government spending to support schools of nursing is *not* extravagance; it is a legitimate government expenditure. How many of us who complain about the performance of government, "get in the hair" of our congressmen—bombard them with protests everytime there is evidence of government wrong-doing?

However, all this has nothing to do with the matter of federal aid to schools of nursing. Let's face all such issues with a fearless and sensible approach!

J. Dewey Lutes
Superintendent

Woonsocket Hospital
Woonsocket, R.I.

Federal Aid? No!

Sirs:

We are building an addition to our hospital, the first unit of which will be four new operating rooms, utility rooms, dressing rooms and sterilizing rooms, all of which will be air conditioned and will be modern and up-to-date in every respect. When completed, and we are expecting to have these completed within the next few weeks, we will have them equipped with the best possible equipment.

This hospital has never accepted any aid from the U.S. government, the state, the county, the city or any charitable organization. In fact, we do not believe in it. We are about the only independent hospital left that I know of which does not receive aid from some of these sources. We do not believe in socialism, communism or federal aid and we are opposed to all of these things.

The Hill-Burton Act is just another effort on the part of the present administration to push the socialization program through from another direction.

At the present time the fate of our country is hanging in the balance, that is, between socialism and the American way of life by which this country became the greatest and most powerful country on the face of the earth with the highest standard of living ever known to mankind.

Unless the pendulum swings to the right very strongly and a *new* administration goes into power in the coming 1952 election, in my opinion that this country is lost forever as far as the original American way of life is concerned. In such an event just what the outcome will be, I do not know but I am convinced that unless we have a definite change of administration under the leadership of someone like Mr. Taft, the future of this country will be very dark indeed. Even at best the outlook is gloomy because of the great public debt and the demoralization of our people and their increasing dependence upon the federal government.

James W. Davis, M.D.

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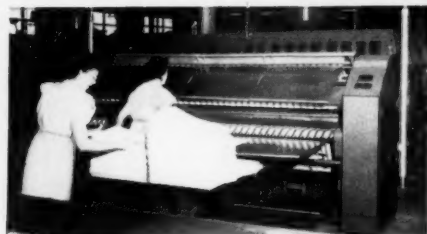
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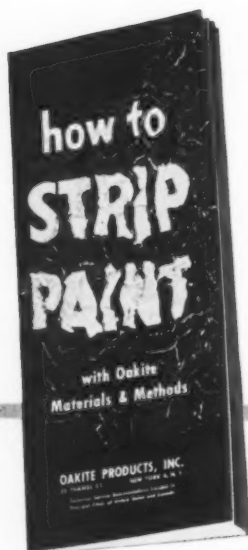
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When the idea of giving complete and free medical care to the people of Egypt began it was believed that, because the health of a nation is of public interest, preparation of the medical care plan should not be restricted to government officials but should be the result of the combined efforts of all possible medical forces in the country.

The plan is the result of group thinking of a committee which was composed of members of wide medical and hospital operating and construction experience, in addition to the government officials. This committee was divided into several branches with each one studying one aspect of the whole problem: How to give the best possible free and accessible medical care to the patient wherever he may be.

Figures and facts needed by the members were given by the various departments of the ministry of public health. The work was organized within each division as well as among all of them. Various branches worked as one team led by the Minister of Public Health, Dr. Abd-El-Gawad Hussein Pasha. Studies and information were interchanged, the different ideas were evaluated, and at the end the master plan was put down.

Two things were borne in mind during this stage of preparation. The first was that the final results arrived at were only the broad outlines of the plan. The details, with respect to each community, would be determined according to local conditions to meet the particular needs of health facilities. The second is the possibility of revising the program because of possible future change in the

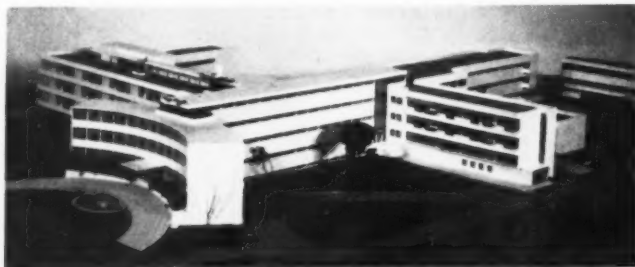
local circumstances of communities. The program was enacted into law and will be carried out in the next 15 years.

A medical survey of the health facilities, governmental and private, was made to determine the number of existing beds per thousand in each inhabited area, the number of beds devoted to each kind of disease, and the number of acceptable beds. It was found that there is an average of one bed per thousand population. The beds are distributed irregularly; while Cairo has 5.5 beds per thousand, some rural areas have 0.5 beds per thousand.

The plan provides three general beds per thousand all over the country by building new hospitals of various sizes and by adding new wings to the recent acceptable ones. The country is divided into medical areas; in the core of each is a base teaching hospital with others of various sizes as its satellites, working together as one unit for prevention, diagnosis and treatment of disease. These hospitals, from the small rural to the big teaching institutions, are coordinated by well planned interchange of patients, information and specialists. The flow of patients runs from small hospitals to large ones as far as their cases need special treatment, while the flow of specialists and personnel runs in the opposite direction. The larger the hospital, the heavier the load it bears and the greater the variety of specialists it will have.

The different kinds of health facilities in the program in each medical area are:

1. Health center for each 15,000 to 20,000 people. As the front line in the program it has two main functions, prevention of disease and treatment of the



Princess Ferial Hospital. Architects: Salah Zeitoon and Mostafa Shawki.

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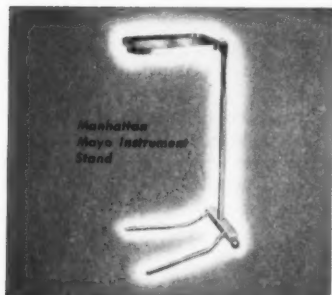
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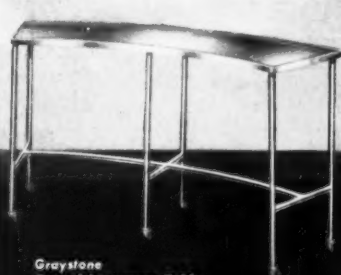
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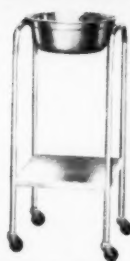
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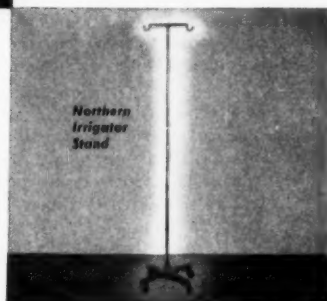
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OPERATING ROOM

FOOD CARRIERS

HYDROTHERAPY & PHYSIOTHERAPY

NURSERY & MATERNITY

PORTABLE X-RAY

You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 24-26 and to the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., April 16-18.

common diseases in the local rural areas. Regular health instructions will be given in each health center and at homes by visiting nurses, especially to mothers before and after delivery. Periodical examinations with x-ray and laboratory tests also will be carried out.

The general sewage, sources of drinking water, and waste disposal in the local area will be controlled and supervised.

2. Rural hospital for each 100,000 to 150,000 inhabitants.

3. Regional hospital for each 1,000,000 to 2,000,000 inhabitants.

4. Teaching hospitals at Cairo, Alexandria, Tanta, Al-Mansoura and Asiot.

These are all general hospitals and attached to each is an outpatient department. Nursing schools and homes will be attached to the large general hospitals.

In spite of the many tuberculosis hospitals existing, the country needs more of them. An adequate number of tuberculosis, mental and chronic disease hospitals will be provided to meet the needs of the whole country.

All medical care given to patients in all these kinds of hospitals will be free,

except that 10 per cent of the beds will be reserved for paying patients.

The money needed for this program is about \$90,000,000. Because of the urgent need, the program was supposed to be carried out within 10 years but owing to the shortage in personnel it was decided to increase the time to 15 years. In this time the medical schools in Egypt will be able to provide the hospitals with enough physicians and nurses.

We found the U.S. Public Health Service very helpful in our efforts to increase the number of hospital designers concerned with the structural aspects of the program. For several months I studied hospital architecture and engineering with the specialists in the Division of Hospital Facilities. I also wish to thank all the people whom I met in the various hospitals and laboratories I visited and who did everything possible to make my visits educational and informative.—ABOU-ZEID RAGEH, architect, projects department, Ministry of Public Health, Cairo.

Gloom Chasers

Among patients in the outpatient department of Memorial Center for Cancer and Allied Diseases, New York, they're known as "Gloom Chasers."

They're volunteers who make waiting in the clinic less tedious and worrisome by serving steaming cups of comforting coffee, accompanied by cookies, and inviting attention to the entertainment afforded by a television set. For those not television minded, racks containing the latest magazines are within reach.

It's wonderful, the change in the morale of patients since the project was first started, executives, doctors and nurses agree. Much of the tenseness that invariably prevails where the public must sit and wait has disappeared. Now everyone, or almost everyone, appears relaxed and at ease. The improved mental state is conducive to a more normal physical reaction. Gone completely are the noise and confusion that formerly existed. Today there is the television to watch.

The project started as an activity of the Society of the Memorial Cancer Center, but so successful did it prove that the hospital has taken over and assumed responsibility for its financing. Some 150 trays are served daily four days a week. The coffee service extends to the examination room, to which a cart is wheeled at regular intervals. The television set was the gift of a friend.

Here is what happens in your hospital when you Standardize on the Standby Model...

DOCTORS AND NURSES find the Standby easy to use—they can read the Exactilt scale instantly whether standing or seated. The Standby neatly fits any location where blood-pressure is measured—is never in the way in wards, operating rooms and outpatient departments.

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Chemicals
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In addition to fresh, active processing chemicals and films with fresh emulsion,

your local Westinghouse office carries a complete line of darkroom accessories — from aprons to ventilators — cabinets to timers. So, remember, whatever your needs, call your Westinghouse X-ray representative for prompt, dependable service.

And for a complete listing of all Westinghouse accessories, just send a card to Westinghouse Electric Corporation, 2519 Wilkens Avenue, Baltimore 3, Maryland.

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We offer **TWO** Baby Incubators, but *They are Not Twins*

THE Armstrong X-4 Baby Incubator, Model 500, is all white. The X-4 is approved by Underwriters' Laboratories for use with oxygen and is designed for use in the nursery. Over 16,000 have been delivered to hospitals and other institutions all over the world.

The Armstrong X-P EXPLOSION-PROOF Baby Incubator, Model 22, is silver-gray with a bright red panel and a red line across the top. The Armstrong X-P EXPLOSION-PROOF Baby Incubator is designed for use in the delivery room and surgery and is approved by Underwriters' Laboratories, Inc. for hazardous areas.



X-4 safe with oxygen for the nursery



*X-P (Explosion-proof)
for delivery room or surgery*

Both of these Armstrong Baby Incubators are designed to supply constant, automatically-controlled safe heat and high humidity for premature and term babies; for the administration of oxygen, either with or without humidity and either with or without heat. Both Incubators are simple. Both are safe. Both are low in cost.

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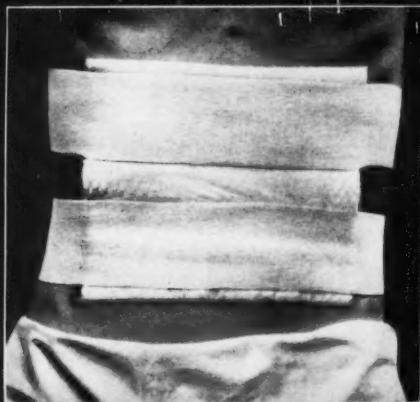
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therapy for lower
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entire body from
chest down.



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Treatment and
Wading Tank for
Subaqua Hydro-
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Thermal Therapy,
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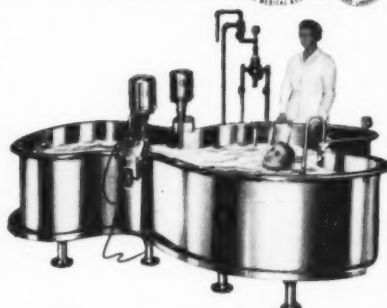
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Hip Tank for
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massage and
Thermal Therapy,
Mobile Model
HM-200 (also
available in sta-
tionary models).



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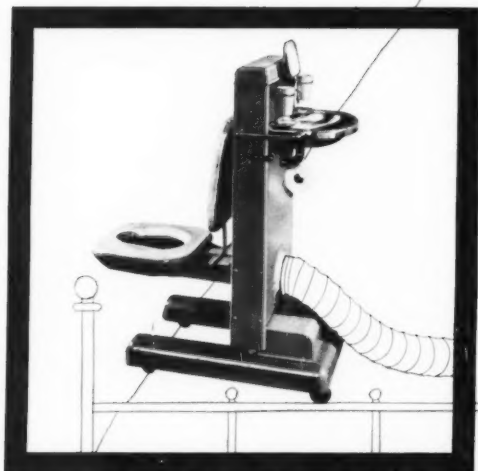
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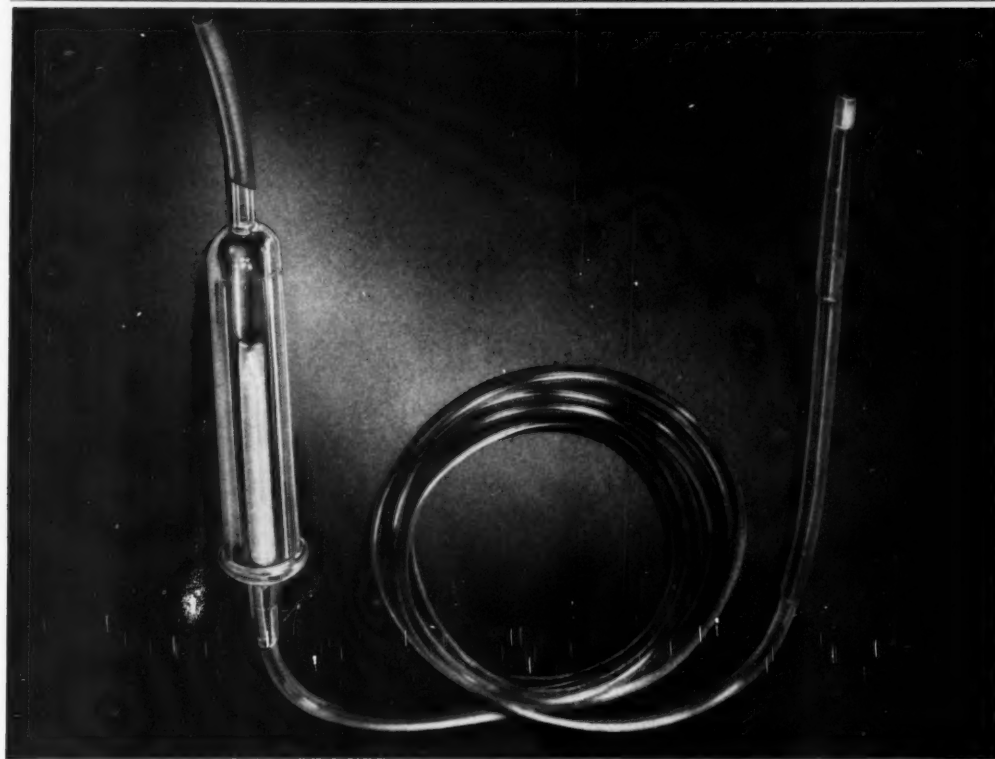


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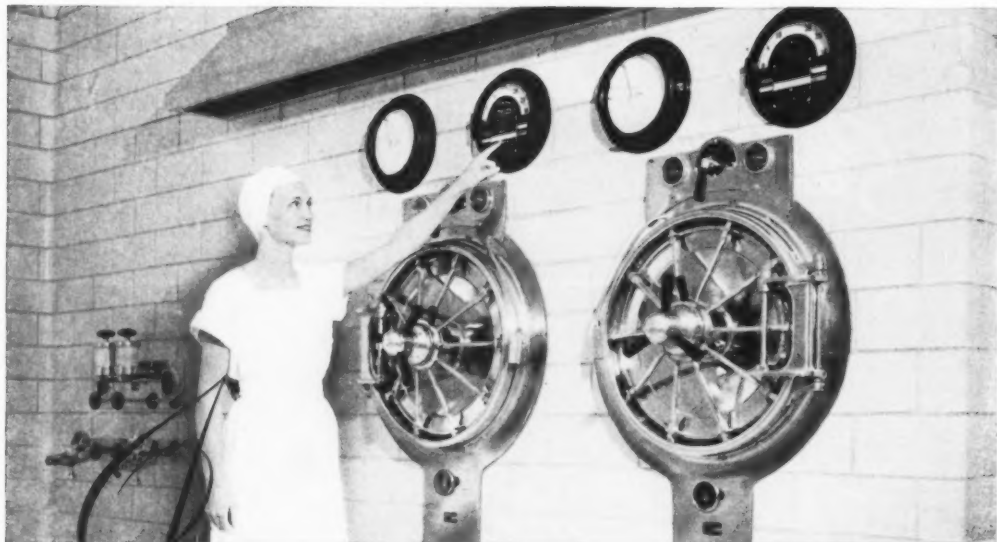
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in its most advanced stage of mechanical development (Sterilock), establishes a new high in patient-safety. It mechanically impounds the load from the instant the safety door is secured, and throughout the entire progressive phases of sterilization.

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(1) Reiser, H. G., et al.: Arch. Surg. 63:568-575, 1951; (2) Stuke, K.: Chirurg. 20:588-595, 1949.



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Architects: Skidmore, Owings & Merrill, Chicago
Consulting Engineer: Samuel R. Lewis, Chicago
Contractor: Lansing Heating & Ventilating Co., Lansing, Mich.



Powers control provides optimum temperature and humidity for patients, doctors and nurses, in operating and recovery rooms, delivery and X-ray rooms and nurseries, private rooms and wards.



Male Ward Building, Western State Hospital, Fort Steilacoom, Wash.
Architect: A. Gordon Lumm, Tacoma, Washington
Engineer: James B. Notkin, Seattle, Wash.
Contractor: P. S. Lord, Portland, Ore.



Proper Temperature—external and internal, hastens recovery of patients.



St. Joseph-Benton Harbor Memorial Hospital, St. Joseph, Mich.
Architects: Fugard, Burt, Wilkinson & Orth, Chicago
Contractor: Northwestern Heating & Plumbing Co., Evanston, Ill.

For Greatest Comfort and Lowest Maintenance Cost Use POWERS Control



POWERS



Comanche County Memorial Hospital, Lawton, Okla.
Architect: Paul Harris, Chickasha, Okla.
Paul H. Fesler, Hospital Consultant
Engineers: Carnahan & Thompson, Oklahoma City, Okla.
Contractor: Ray F. Fischer Co.



Veterans Administration Hospital, West Haven, Conn.

Left: 400 bed Tuberculosis Bldg.; Right: 500 bed General Medical & Surgical Bldg.
Architects: Curtin and Riley, Boston, Mass.
Engineers: Corps of Army Engrs., Boston District
Contractor: Raisler Corp., New York City



Morristown Memorial Hospital, Morristown, N. J.
Architects: John H. & Wilson C. Ely, Newark, N. J.
Hospital Consultant: Gerhard Hartman, Ph. D., New York City
Mechanical Engineers: Meyer, Strong & Jones, New York City
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(a75)

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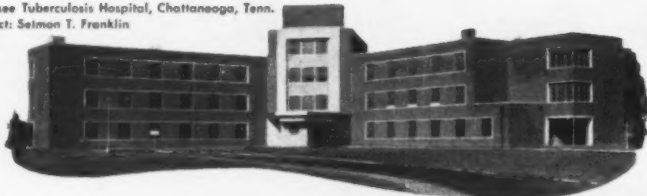


Helen Rivas Clinic, Rochester, N. Y.
Architects: Kaelber & Wassdorp



Indiana State Board of Health Bldg., Indianapolis, Ind.
Architects: Leonard & Matthews

Tennessee Tuberculosis Hospital, Chattanooga, Tenn.
Architect: Selmon T. Franklin



Georgia Baptist Hospital, Atlanta, Ga.
Architects: Stevens & Wilkinson, Inc.



Tripler Memorial Hospital, Oahu, Territory of Hawaii
Architects: York & Sawyer, U. S. Army Corps of Engineers



Mercy Hospital, Springfield, Ohio
Architects: Maguolo & Quick



Bradford Hospital, Bradford, Pa.
Architect: Thomas K. Hendryx

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If you're looking for hospital windows that are long on good looks and lighter-than-air on an operating budget...

... you'll almost surely choose *aluminum* windows. Today, they're first choice in hospitals everywhere.

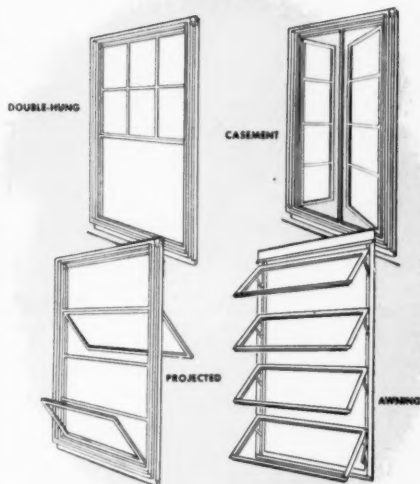
But, when you specify, be sure you say, "Quality-Approved aluminum windows."

Then you can be sure of windows with a "clean bill of health," windows that have been *tested and approved* by an independent laboratory for strength of sections, quality of materials, low air infiltration and sound construction.

Consider the advantages all these quality features will give the hospital buildings you plan. More light and visibility because the rugged aluminum extrusions make narrower frames possible! Easy, trouble-free operation and draftproof ventilation! Real long-run economy, because these windows will never need painting, replacements or costly upkeep!

You can get Quality-Approved aluminum windows, double-hung, casement, projected or awning types, in styles and sizes to suit your plans.

You can get complete information from any Quality-Approved manufacturer, from Sweet's Catalog (Section 17a/ALU), or from the address below. A copy of our Booklet, "Aluminum Window Specifications" is free on request. Address Dept. MH-3.



Aluminum Window Manufacturers Association

74 Trinity Place, New York 6, N. Y.

TESTED

**For
Quality
Materials**



TESTED

**For
Sound
Construction**



TESTED

**For
Strength
of Sections**



TESTED

**For
Low
Air Infiltration**



Give your salads the taste millions prefer

THE ONE AND ONLY MIRACLE WHIP



Miracle Whip is far and away America's favorite salad dressing. In food stores across the country it *outsells the next 20 leading brands combined!*

There is a great *difference* in salad dressings. There has to be, to explain the overwhelming popularity of Miracle Whip.

Miracle Whip has a can't-be-copied flavor. It's made by a secret recipe that combines the qualities of zesty boiled dressing and fine may-

onnaise mixed satin smooth in a special Kraft beater.

Not too peppery, not too mild, creamy smooth Miracle Whip has the flavor millions agree is *just-right!* Such a dressing is sure to please *more* of your customers...make more salad sales for you.

Give Miracle Whip a trial. Place an order for a 1-gallon jar or 3-gallon can with your jobber or Kraft salesman today.

The Nation's Taste is your best Buying Guide



FRENCH . . . WITH OR WITHOUT THE TOUCH OF GARLIC

Kraft French is the most widely popular French Dressing ever created. A creamy-thick dressing, with a marvelous blend of seasonings. Smooth flavor that's zippy yet mild.

Miracle French is for the folks who like a hearty flavor. A clear dressing—seasoned the Parisian way with just the right touch of onion and garlic.



TRUE MAYONNAISE AT ITS FINEST

Kraft Mayonnaise is true mayonnaise because it is made solely of fine salad oils and eggs, fragrant vinegar and seasoning. Nothing else. Kraft is generous with the costly salad oils to bring you mayonnaise that's luxuriously rich. Kraft insists on really choice ingredients, blends them in just the right proportions for the most delightful flavor. And Kraft's own special beater gives it a velvety smooth texture. Your customers will agree that Kraft Mayonnaise is true mayonnaise at its finest.



BRAND NEW! THE ALL-PURPOSE SEA ISLAND DRESSING

Here's a new and different *special* dressing that's made a big hit in every market where it has been introduced. Creamy rich . . . fine mayonnaise base. Breezy flavor . . . lively seasoning, including garlic. Adds zip to salads, seafoods and sandwiches. Give Sea Island a try. Your customers will comment on it.



TWO MOST POPULAR MUSTARDS . . . AND NEW CREAM-STYLE HORSERADISH!

If you serve a mild mustard—there's *Kraft Salad Mustard*. A top-quality mustard. *Kraft Horseradish* mustard is satin-smooth—perked up with just the right amount of horseradish. And Kraft has the finest *horseradish* you can serve . . . *Kraft Cream-Style Horseradish*! It's fresh horseradish, ground fine, and blended just-so with fragrant vinegar and pure cream.

KRAFT
Foods Company
INSTITUTIONAL
DIVISION

Distributed direct and through service-minded jobbers everywhere BULK AND PORTION
NATURAL CHEESES (imported and domestic) • PASTEURIZED PROCESS CHEESES
CREAM CHEESES • GRATED CHEESES • KRAFT KITCHEN FRESH MAYONNAISE
MIRACLE WHIP SALAD DRESSING • KRAFT FRENCH AND MIRACLE FRENCH
DRESSINGS • CUISINE SALAD DRESSING • SEA ISLAND DRESSING • MUSTARDS
HORSERADISH • SALAD OIL • PARKAY MARGARINE • MALTED MILK



TEL-O-SEAL CONTAINERS

For I.V. solutions. Permits routine sterility check during storage period. Available in 350, 500, 1000, 1500 and 2000 ml. sizes.



POUR-O-VAC CONTAINERS

For sterile water and saline technics. Available in 350, 500, 1000, 1500, 2000 and 3000 ml. sizes.



AMP-O-VAC—

The Reusable Ampule

Reduces the waste of novocaine and similar medications by permitting periodic withdrawals as required without exposing balance of contents to air. Container and hermetic closure may be repeatedly sterilized. Available in 75 ml. size only.

• Fenwal representatives are equipped to assist you in the selection, installation and operation of equipment best adapted to meet the volume requirements of your hospital.

Of immediate importance to you ...the HOSPITAL PHARMACIST

In spite of the current spiral of inflationary costs, your skill plus Fenwal Equipment and Technics can effect drastic reductions in the cost of intravenous solutions for your hospital.

FENWAL ASSURES SAFETY, ACCURACY AND CONVENIENCE

- 1 Standardized equipment and technics which cover every phase of I.V. therapy; sterile water procedure; preparation of antibiotics in solution.
- 2 Specially designed PYREX Brand glass containers from 75 ml. to 3000 ml. Six practical sizes that accommodate interchangeable hermetic seals.
- 3 Reusable vacuum closures.
- 4 Automatic washing and filling equipment and accessory apparatus.
- 5 A background of 10 years of satisfactory operation in many leading hospitals throughout the world.

FENWAL offers to hospital pharmacists, by virtue of their scientific training, experience and position, the means of effecting substantial and immediate economies for affiliated hospitals... and in addition... the opportunity to enhance the prestige of their pharmacy services.

HEADQUARTERS FOR SCIENTIFIC
GLASS BLOWING, LABORATORY
AND CLINICAL RESEARCH AP-
PARATUS, REAGENT CHEMICALS



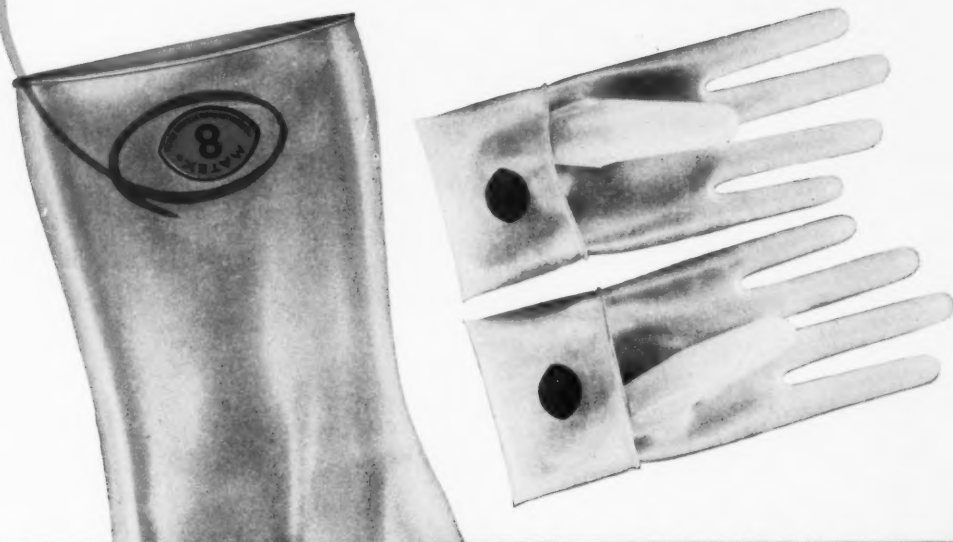
ORDER TODAY or write today
for further information

**MACALASTER BICKNELL
COMPANY**

243 Broadway Cambridge 39, Massachusetts

HERE

*is the practical solution
to GLOVE SORTING!*



Permanent SIZE MARKINGS



Now, with Matex Kwiksort gloves, mismatching is a problem of the past. Glove sizes are permanently and indelibly marked in figures — that won't wear off, rub off, steam off, or fade off.

In addition to permanent figures, each size is further identified by the design background; size 7 is a circle, size 7 1/2 a square, size 8 an oval. This design can be seen even when the glove is inside out.

Those hospitals, that have cooperated with us in testing Kwiksort gloves, all claim that this identification plan speeds glove sorting and positively eliminates mismatching.

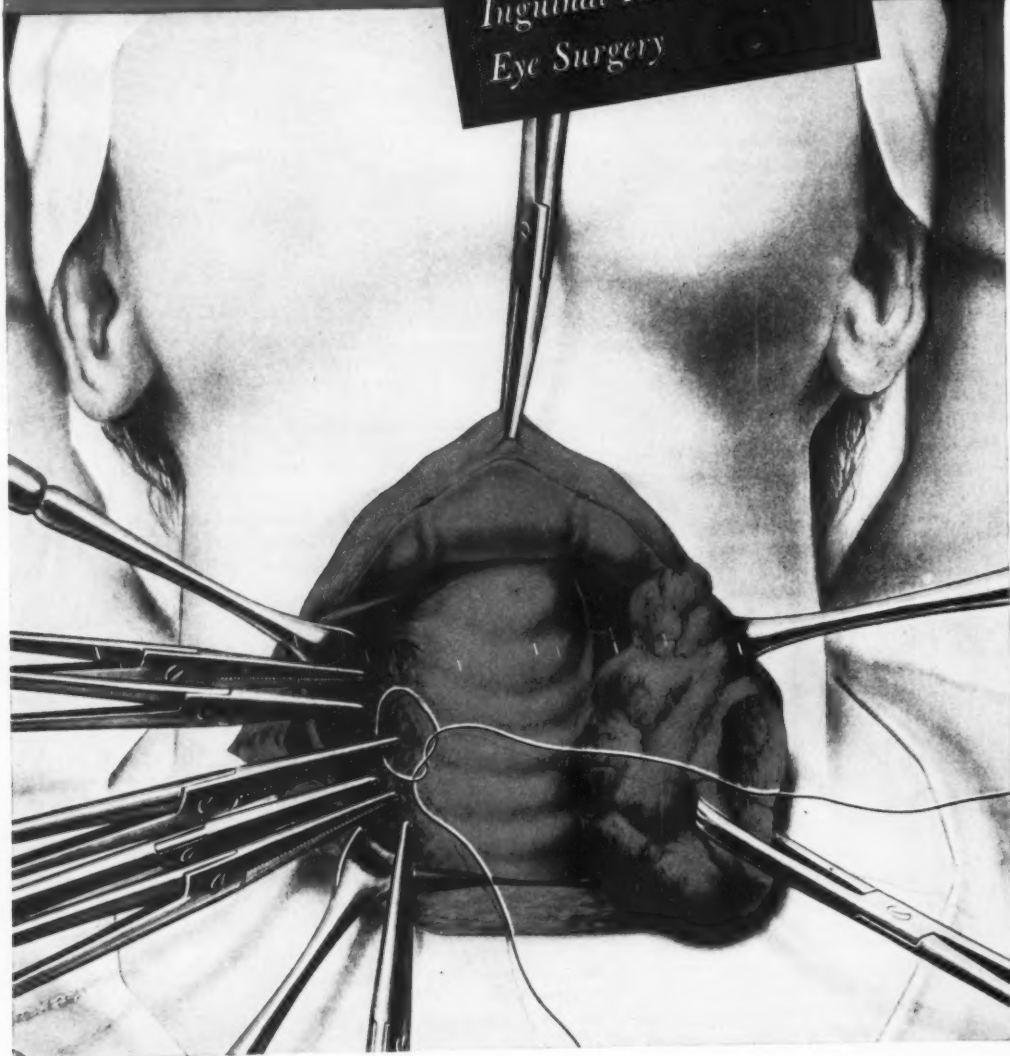
Your Matex Dealer can soon supply you with Matex Kwiksort, smooth or dermatized, or Massillon Latex (brown) Kwiksort.

THE MASSILLON RUBBER CO.
MASSILLON, OHIO



*Whenever "silk technic" is the
surgeon's choice...*

Thyroidectomy
Gastric Resection
Inguinal Herniorrhaphy
Eye Surgery

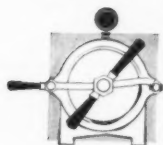


New improved **ANACAP[®]**
SURGICAL SILK

5 *ways better than ever before*



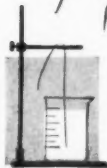
- 1. Greater tensile strength:** One of the strongest silks ever created—smaller diameter sizes can be used everywhere to minimize trauma and foreign body reaction.



- 2. Withstands repeated sterilization:** New Anacap Silk can be boiled or autoclaved *six separate times* without appreciable change in either strength or texture. In laboratory tests almost the full original strength is maintained even after 23½ hours of boiling.



- 3. Easier to handle:** Firmer, not limp, Anacap Silk speeds operative technic. Braided by a new method that minimizes "splintering" and "whiskering" it passes readily through tissues. The ease of handling Anacap makes it a "new experience" in silk suturing.



- 4. Absolute non-capillarity:** Having no wick-like action, new Anacap Silk is resistant to body fluids and will not spread an early localized infection if it occurs.

- 5. Doubly economical:** Low in original purchase price, new Anacap Silk is also low in individual suture cost because of its long sterilization life.

In sizes 6-0 to 5 on spools of 25 and 100 yards; sterile in tubes with and without D & G Atraumatic[®] needles attached.

DAVIS & GECK, INC.

57 Willoughby Street,



Brooklyn 1, N. Y.

Which of these two elastic bandages is truly elastic?

*The bandage on the left is TENSOR
—woven with live rubber threads*

The photo tells the story. *Live rubber* threads in Tensor make the difference. Tensor doesn't depend merely on the weave of its fabric for elasticity.

Patients welcome greater mobility and comfort with Tensor. Firm, steady support where it's needed. Tensor stays put, retains proper pressure without frequent readjustment.

And Tensor *stays* elastic even after prolonged wear, stretching and laundering.

Isn't Tensor, then, your wisest possible investment in elastic bandages?

TENSOR[®]
ELASTIC BANDAGES
—woven with live rubber threads

(BAUER & BLACK)

Division of The Kendall Company
309 W. Jackson Blvd., Chicago 6, Ill.

Other famous Bauer & Black Elastic Supports: Bracer Supporter
Belt, Elastic Stockings, Abdominal Belts, Suspensories, Anklets,
Knee Caps, Athletic Supporters*

*Reg. U. S. Pat. Off.



TENSOR depends on live rubber threads for greater elasticity.

CONVENTIONAL elastic bandage is all cotton, can't have Tensor's elasticity.

...Your Glove Sorting
Is Now Quicker
and Easier



with
**Multi-Size
Markings**
by **PIONEER**

*Specify
Specify
Specify*

PIONEER
Surgical Gloves

No Color Code to Memorize

...7-1/2 7-1/2 7-1/2 7-1/2 7-1/2 7-1/2—size is printed in a row clear across the cuff of the glove.

Sticks out of any pile of gloves—highly visible.
And gloves pulled from the pile for pairing bring other size markings into view.

It's quick, it's easy—it saves time and labor cost.
No color code to memorize. It's a strong reason to specify PIONEER gloves.

No extra charge for this new feature on Rollprufs and other styles of Pioneer surgical gloves.

Rollprufs
TM of TPRCo.

the

PIONEER

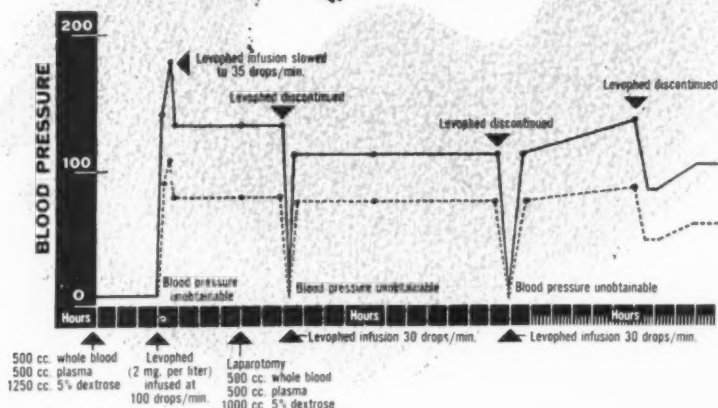
Rubber Company

750 TIFFIN ROAD • WILLARD, OHIO

New..

The Most Powerful
Pressor Antidote for

SHOCK



LEVOPHED®

BRAND OF LEVO-ARTERENOL (NOR-EPINEPHRINE)

Prompt, Predictable, Reliable, Easily Controlled Action

Clinical experience with Levophed has demonstrated the dramatic, often life-saving action of the drug.

Levophed is indicated for the elevation and maintenance of blood pressure during all stages of shock, including profound, advanced, prolonged and so-called "irreversible" shock, as well as other acute hypotensive states associated with surgical and non-surgical trauma, hemorrhage, disease and central vasomotor depression.

SUPPLIED: Levophed solution 1:1000 in ampuls of 4 cc. (boxes of 10), to be administered in 1000 cc. of infusion fluid.

Write for pamphlet giving a detailed discussion of clinical experience with Levophed and its manner of use.

Winthrop Stearns Inc.
NEW YORK 18, N. Y. WINDSOR, ONT.

Levophed, trademark reg. U. S. & Canada

THERE BY VIRTUE OF QUALITY

ETHICON
Surgical gut

Ethicon's exclusive processes of Tru-Gauging and Tru-Chromicizing catgut insure greater uniformity of gauge, strength and chrome distribution. All Ethicon Sutures must meet the rigid Ethicon quality control requirements which are well above U. S. P. standards.

ETHICON SUTURE LABORATORIES INCORPORATED
NEW BRUNSWICK, N. J.

has EVERY

precaution been taken..?



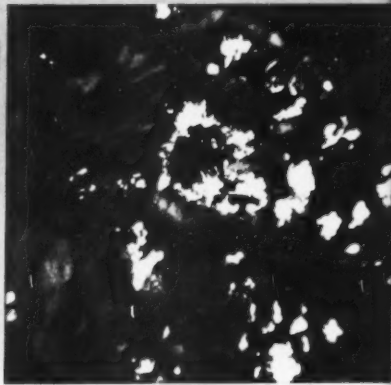
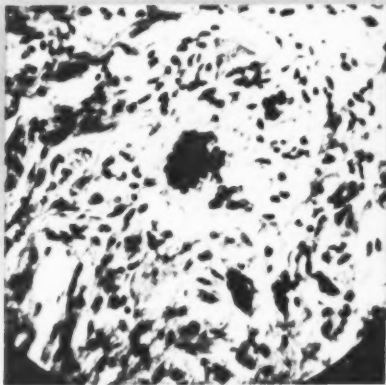
Every precaution has not been taken unless, in addition to all other measures, BIO-SORB is used as a glove lubricant, for BIO-SORB completely eliminates glove powder adhesions—thus helping to reduce the likelihood of postoperative complications.

All published reports agree that talc as a glove lubricant is unsafe. The hazards inherent in its use are virtually impossible to eliminate, for implantation of talc may occur in many ways—from unwashed gloves, perforations in gloves, spillage onto sponges, instruments and suture material, and by the air-borne route.

BIO-SORB obviates these dangers because it

- minimizes intra-abdominal adhesions, formation of persistent sinuses and nodules in wounds
- avoids granulomatous tissue reactions which lead to adhesions

Routine use of BIO-SORB in the glove-preparation room eliminates the danger of pneumonokoniosis from talc.



Talc granulomas in myometrium. Identical fields, left under ordinary, right under polarized light.

BIO-SORB[®] POWDER

BIO-SORB not only is safe, but is a more efficient glove lubricant than talc. BIO-SORB is convenient, economical; BIO-SORB is readily sterilized by autoclaving. It does not produce deterioration of rubber gloves, and is readily adapted to all established OR technics.

BIO-SORB was developed in cooperation with National Starch Products, Inc.

Supplied: individual service packets, ready to autoclave
5 pound cans

ETHICON SUTURE LABORATORIES INCORPORATED

Suture Laboratories at New Brunswick, N. J.; Chicago, Ill.; Sao Paulo, Brazil; Sydney, Australia; Edinburgh, Scotland.

Angelica... for all hospital apparel



longer-lasting patient gowns that save money

Thorough Research
Makes Angelica First
in Hospital Apparel
Development
Since 1878

What do you look for in hospital apparel? Fine workmanship? Sturdy materials? Other money-saving features? You can depend on Angelica for all these. Each Angelica garment you buy, whether for the wards, surgery, dietary or maintenance, reflects Angelica's 73 years of experience in the hospital field. That's why over 5,000 hospitals from coast to coast are look-

ing to Angelica for all hospital apparel needs.

You'll find Angelica patient gowns combine extra comfort with extra strength and durability. A wide choice of materials includes Monte® Cloth, which has been proven 25% longer-lasting in hospital tests.

If you are interested in lower apparel costs ... call your Angelica representative today.

[®]Reg.

Angelica

UNIFORM COMPANY

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1101 S. Main, Los Angeles 15

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BLODGETT PREPARES

70% of all cooked foods ON YOUR MENU



BAKING

One deck holds
twelve 10 in. Pie
Tins or two 18 x
26 Bun Pans.

COOKING

One deck holds
as many as 116
Casseroles or
equal capacity.

ROASTING

One deck has ca-
pacity for five 25
lb. turkeys or
equal capacity.

*Blodgett
Does all three
Better...*

*and at the
same time!*



You can roast, bake and do general oven cookery in a Blodgett oven because of its flexibility and large capacity. Each section is separately controlled for proper heat. Foods requiring different temperatures are cooked in different decks at the same time; in one section, meat is roasted at low temperature, 300°F., thus preventing excess meat shrinkage and providing more servings per pound; in another, appetizing, high quality pies, muffins and biscuits can be baked at 425°F.; while scalloped dishes, casseroles and meat pies are cooked in still another at 350°F.

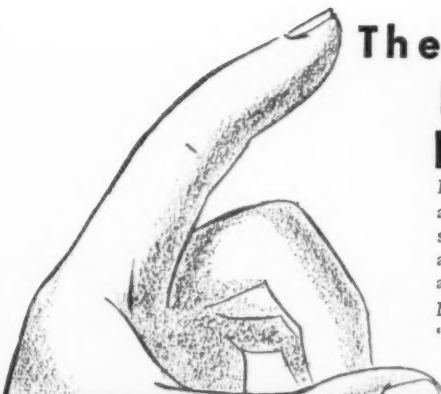
A Blodgett is continually producing for you because it can take care of as much as 70% of the cooked food items on your menu. Blodgett's rugged construction assures long life; its engineering "know-how" means uninterrupted service. A Blodgett gas-fired oven costs less to buy . . . less to install . . . less to maintain . . . uses less kitchen space . . . with lower fuel bills.

Write for Blodgett's new full-color accordion folder for further details; and see your Food Service Equipment Dealer.



the G. S. **BLODGETT** CO., INC.

50 LAKESIDE AVE.
BURLINGTON, VT.



The *New* "DIET-MASTER" FOOD CONVEYOR

one compact unit for all foods

Make your own inset arrangements to fit your needs. Simply arrange the various size rectangular and square insets to suit your selective menus. Note the two round wells for soups, etc., and the two heated drawers for bread and rolls. Other models available with additional round wells.

Made entirely of heavy gauge STAINLESS STEEL, the Prometheus "DIET-MASTER" is built for years of service.

UNDERWRITER'S APPROVED.



Write for catalog of Prometheus Operating Lights, Sterilizers, Food Conveyors and other hospital equipment.

PROMETHEUS

ELECTRIC CORPORATION
50 Webster Ave., New Rochelle, N. Y.



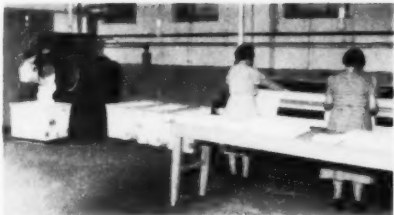
this
hospital
found
the remedy

for L.O.

In modernized laundry of James Lawrence Kernan Hospital, work is quickly washed sterile-clean in these two CASCADE Washers. Excess water is then rapidly and gently removed in Extractor at far right.



Linens are beautifully ironed on RETRON Flat-work Ironer (right). Work not to be ironed is quickly fluff-dried in ZONE-AIR Tumbler (left).



One operator neatly irons nurses' uniforms and other garments on this push-button-operated Press Unit.



With the many matters that each day cross the desk of a hospital administrator, the problem of *Laundry Overload* is sometimes overlooked. If left unchecked, **L.O.** can drastically impair the efficiency of any hospital, large or small.

Laundry Overload is the result of added clean linen demands on present, inadequate laundry facilities, due to:

- More rapid turnover of patients, necessitating more frequent complete change of linens.
- Greater number of operations performed daily, requiring more linens and uniforms.
- More of the hospital personnel now uniformed.
- Increased "out-patient" service, necessitating the use of more linens.

Officials of 85-bed James Lawrence Kernan Hospital for Crippled Children, Baltimore, Md., found the remedy for **L.O.** when they called in an AMERICAN Laundry Advisor. After a detailed survey of the Hospital's clean linen requirements, he recommended modernization of the laundry with equipment that would turn out more work faster at lower cost.

Now **L.O.** no longer limits the Hospital's clean linen supply, and management reports better quality work, with less floor space used.

Hospitals all over the world have found that AMERICAN-planned laundries *reduce costs ... require fewer operators ... shorten work hours ... return linens to service faster ... permit smaller linen inventory.*

Keep up with YOUR increased linen needs by modernizing your laundry with more productive, economical-to-operate AMERICAN equipment. WRITE TODAY for the free services of an AMERICAN Laundry Advisor.

Remember...

Every Department of Your Hospital
Depends on the Laundry.

The
AMERICAN
LAUNDRY MACHINERY CO.

CINCINNATI 12, OHIO



MORE OPERATIONS PER PAIR!!!



THAT, as you know, is the secret of reduced glove costs—the only answer to inflation—more wear from every pair of Surgeons' gloves. Wiltex White or Wilco Brown Curved Finger Latex Gloves DO give you more operations per pair. Tests in leading hospitals over the country have proven this to be true. Wiltex has safely undergone over fifty sterilizations in these tests, while Wilco remains in service even after thirty or more trips to the autoclave. This longer life naturally reduces the per-unit cost of these internationally famous gloves at each operation. The curved fingers, together with Wilson's corrected hand styling, makes for greater comfort and less hand strain for the surgeon—features that keep Wiltex and Wilco well to the top of the preferred list.

**Keep
UPKEEP
Down**

The Wilson

RUBBER COMPANY

THE WORLD'S LARGEST EXCLUSIVE MANUFACTURERS OF RUBBER GLOVES

CANTON · OHIO



Whatever your requirements, choose
PURITAN HUMIDIFIERS
 for Oxygen Therapy

• **SAVE TIME FOR PERSONNEL**

Easily and quickly put into service, and constant attention is not required.

• **ASSURE PROPER HUMIDITY**

Units for either regular or extra-high humidification therapy, as prescribed.

• **SERVE WITH SAFETY FOR MANY YEARS**

Meticulously built of first quality materials in strong, uncomplicated design.



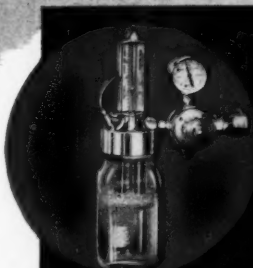
Since 1913

PURITAN COMPRESSED GAS CORPORATION

KANSAS CITY CHICAGO CINCINNATI ST. PAUL DETROIT ST. LOUIS
 BALTIMORE BOSTON NEW YORK DALLAS ATLANTA

"Puritan Maid" Anesthetic, Therapeutic and Resuscitating Gases and Gas Therapy Equipment, including Equipment for Hospital Oxygen Piping Systems.

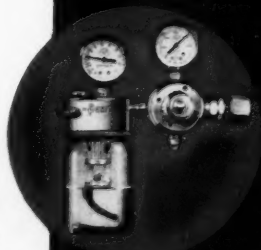
DEALERS IN MOST PRINCIPAL CITIES



OXIFIER A universal standard humidifier, complete with regulator.

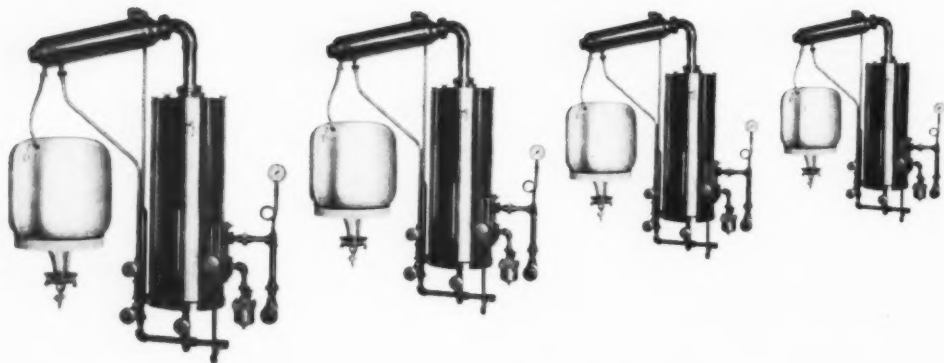


HUMIDIFIER 21B5 High efficiency at low cost. Use with most standard regulators.



OXIJET For extra-high humidity. Complete with regulator.

• The Name You Trust •



Barnstead

for **PURE DISTILLED WATER**

SINCE 1878, leading hospitals everywhere have put their confidence and trust in Barnstead for their Pure Water requirements. For Barnstead Stills, noted for their scientifically correct design produce pure, sterile water, far above U.S.P. specifications with a minimum of cleaning and attention.

Barnstead Stills have set Pure Water standards throughout the world. With a Barnstead you can be sure of water of the highest purity . . . water that is free from organic, inorganic solids, bacteria, pyrogens, and dissolved gases, for every exacting hospital need.

And whether you require single, double or triple distillation . . . in the Laboratory, Pharmacy or Central Supply . . . Barnstead, with over 200 different sizes and styles, has the exact still to solve your particular Pure Distilled Water problem.

Write for Special Hospital Bulletin #116, "Barnstead Stills, Especially Selected For Hospitals." It gives prices, dimensions, pipe sizes, capacities, fuel requirements and other helpful information.

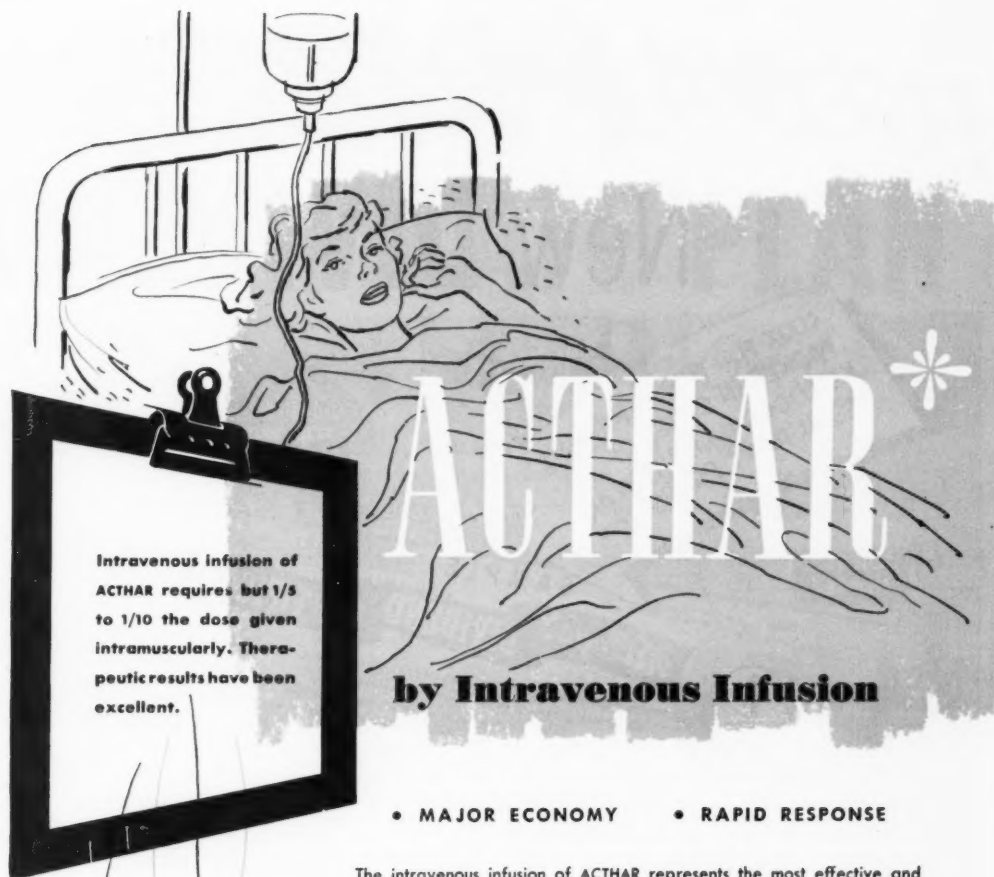
THESE BARNSTEAD FEATURES ARE YOUR GUARANTEE OF THE PUREST DISTILLED WATER

- The famed Barnstead Condenser — the only condenser that separates and expels gaseous impurities. An important factor in hospital work.
- Scientifically designed evaporators operating at low vapor velocity have ample steam disengaging space. Distillate cannot be contaminated by raw-water carry-over.
- Spanish Prison Baffles remove minute entrainment and pyrogens.
- Barnstead Stills stay on the job for months between cleanings. Large clean-out opening makes cleaning easy.

TRADE MARK REG. U.S. PAT. OFF.
Barnstead
STILL & STERILIZER CO.

First in Pure Water since 1878

31 Lanesville Terrace, Forest Hills, Boston 31, Mass.



ACTHAR

by Intravenous Infusion

- MAJOR ECONOMY
- RAPID RESPONSE

The intravenous infusion of ACTHAR represents the most effective and economical method in initiating ACTH therapy, particularly in severe or imminently grave conditions. Indicated in acute sensitivity reactions such as drug or serum reactions, acute disseminated lupus erythematosus, pemphigus, most acute inflammatory diseases of the eye, adrenal cortical atrophy following prolonged or excessive adrenocortical substitution therapy, and pre- and postoperatively in surgery of the adrenal gland.

Twenty International Units of ACTHAR given over an eight-hour period provide activation of the adrenal cortex for approximately twenty-four hours, rapidly initiating therapy. As treatment continues, the dose can be decreased to as little as 5 I.U. a day.

ACTHAR (lyophilized powder) is supplied in vials of 10, 15, 25 and 40 I.U.

*THE ARMOUR LABORATORIES BRAND OF ADRENOCORTICOTROPIC HORMONE (CORTICOTROPIN—ACTH)



THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

FOR YOU! **PRIZES...** New **DIVIDEND**

**LOOK FOR THIS CERTIFICATE
PACKED IN CASES OF
KELLOGG'S INSTITUTION AND
RESTAURANT PRODUCTS***

FOR THE HOME!

FOR YOUR BUSINESS!

FOR YOU!

**THIS CERTIFICATE
WORTH
10
PRIZE POINTS**

**See Other Side
CASH IN!**

Kellogg's DIVIDEND CERTIFICATE

REDEEM THIS CERTIFICATE FOR PREMIUMS OR CASH, AT YOUR OPTION. Each dividend certificate has a prize point value of 10 points or a cash value of two cents.

We reserve the right to discontinue any or all articles listed in the Kellogg's Prize Point Index or Kellogg's Prize Catalog and to change the redemption value thereof without notice.

This certificate is not to be issued beyond the continental limits of the United States or in any place where its issuance, use, or redemption is taxed, licensed, restricted or prohibited by law. Not redeemable by Government employees prohibited by law from receiving same. Redeemable only by authorized representatives of Institutions and Restaurants using Kellogg Company products, and receiving this certificate in the regular course of business.

VOID AFTER DEC. 31, 1952, UNLESS EXTENDED

SAMPLE

SAMPLE

WORTH 10 PRIZE POINTS

FOR HER!

**START SAVING
CERTIFICATES
TODAY!**

**NOW, MORE THAN EVER,
ALL FAVORITE CEREALS**



with Kellogg's Great CERTIFICATE PLAN

Thousands of Valuable Gifts

Now ... in cases of Kellogg's Individual Cereals ... a Dividend Certificate for you! Save them ... and get ... at no extra cost ... your choice of wonderful, valuable gifts!

YOU'LL FIND famous brand name products ... like Elgin watches ... Ronson lighters ... Oneida Sterling ... Kodak cameras ... G-E appliances ... Philco radios ... and hundreds of others.

HOW TO GET THEM? Easy! Just save your Kellogg Dividend Certificates, and when you collect the required amount, mail them in and we'll send you your prize.

WHATEVER YOU WANT IS HERE! Yours this easy way ... costs you not a penny extra ... a

great added bonus for serving *more* Kellogg cereals!

REMEMBER, the more you serve, the faster you earn prizes! Here's a handy suggestion ...

Kellogg's cereals are an economical, main-dish breakfast, and each individual package stays fresh and sanitary until opened. Ready to serve in a jiffy. Your patients will enjoy the flavor of Kellogg's cereals —and they're nutritious, too. So be sure to include a Kellogg's cereal on your breakfast trays.

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* **THE KELLOGG'S PRIZE POINT INDEX** and the **KELLOGG'S PRIZE CATALOG** list the cases of Kellogg's Individual Cereals in which you will find the Kellogg Dividend Certificates. They also show the exact number of prize points required to obtain the prize you select. You will find the Prize Point Index packaged in cases of Kellogg's Individual Cereals.

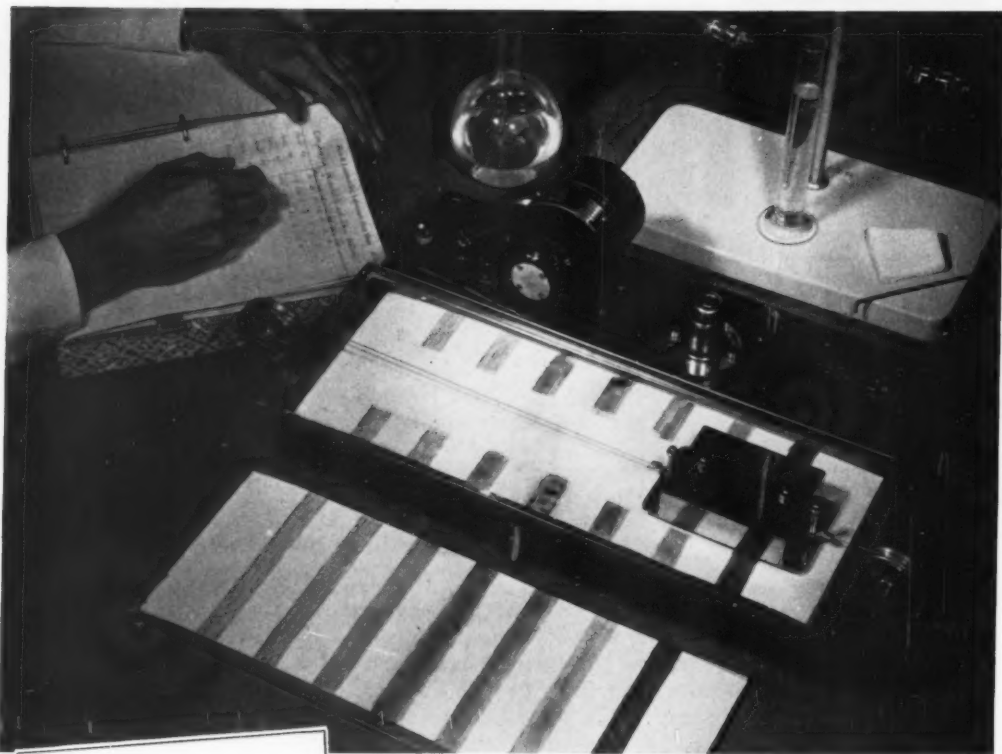
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Oakwood Hospital, Dearborn, Michigan was the September, 1951, choice for Modern Hospital of the Month



Architect: SCHMIDT, GARDEN & ERIKSON, Chicago, Ill.
October, 1951—St. Luke's Hospital, Saginaw, Michigan



Architect: MAGNEY, TUSLER & SETTER, Minneapolis, Minn.
November, 1951—Variety Club Heart Hospital of the University of Minnesota Hospitals, Minneapolis, Minn.



Architect: ISADORE ROSENFELD, New York, N.Y.
December, 1951—North Shore Hospital, Manhasset, L. I., New York.
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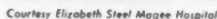
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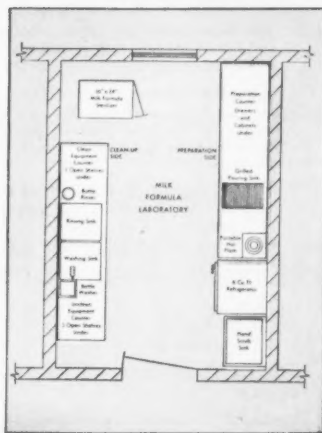


Courtesy Shodyside Hospital

must have adequate space for segregation of "clean-up" and "preparation" areas. Operating efficiency and safety are dependent upon proper arrangement of counters, cabinets, sinks and essential sterilizing equipment.

is frequently unable to allocate sufficient space for the preferred two-room (segregated) plan. This plan is typical of a small formula room designed to operate with efficiency and safety under competent supervision.

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Small Hospital Questions

Fair Trade Act

Question: Do the provisions of the Fair Trade Practice Act of the federal government cover purchases of equipment and supplies by hospitals?—B.H.T., Ill.

ANSWER: The following quotation from P.L. 550 seems to indicate clearly that hospitals are not bound in their purchases by provisions of the Fair Trade Practice Act: "To amend Public Law 692, 74th Congress, Second Session, be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that nothing in the act approved June 19, 1936 (Public Law No. 692, 74th Congress, Second Session) known as the Robinson Patman Anti-Discrimination Act shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals and charitable institutions not operated for a profit." This act was approved May 26, 1938.—E. W. JONES.

Hospital Pharmacists Needed

Question: May I have your opinion as to how many pharmacists should be employed in a hospital pharmacy on the basis of the bed capacity of the hospital?—S.B., Wyo.

ANSWER: It is difficult to give any really reliable guide as to just how many hospital beds can be properly serviced by one pharmacist. So many things enter into the situation. As an example: Does the hospital have an active outpatient clinic for poor people and does it have an active pay outpatient clinic? If such clinics are in operation the volume of work in the pharmacy for outpatients might exceed the volume of work for inpatients.

Many people who have studied this problem over a long period of time feel that a hospital with only 75 to 100 beds cannot afford to be without the full-time services of a qualified pharmacist. As a general rule these small hospitals, unless they have an extremely active and high volume outpatient clinic, could not keep a pharmacist busy all of the time. However, it is felt that the pharmacist could take on such other duties as purchasing or chief of the storeroom so that his time would be well occupied. A pharmacist in a hospital of 75 to 100 beds, combining a

few other duties with his pharmaceutical job, probably could repay the hospital many times over, even though he is paid a good adequate salary. The savings inherent in having a pharmacist in a hospital are great.

One pharmacy in a hospital of about 500 beds with an outpatient visit volume of about 150 a day has three full-time pharmacists who are kept very busy.

Standard plans have been developed for hospital pharmacies of 50, 100 and 200 bed general hospitals by the Division of Hospital Facilities, U.S. Public Health Service. These plans were worked out in cooperation with the American Pharmaceutical Association and the American Society of Hospital Pharmacists. They were printed in the *Bulletin* of the American Society of Hospital Pharmacists in January and February, and May and June of 1950. Reprints are available from the Division of Hospital Facilities, Public Health Service. This same pamphlet contains the minimum standards for pharmacies in hospitals.—E. W. JONES.

Approves Laboratory Charge

Question: If our hospital adopts the policy of having certain procedures, such as a Wassermann, a Kahn test or chest x-ray test, performed for all patients, is it proper to make a charge for the procedure which the patient did not choose himself?—D.C., Mo.

ANSWER: It certainly is. Such routine testing programs are undertaken for the benefit of the whole community, and importantly, for the benefit of the in-

dividual patient for whom the diagnostic procedures are conducted, so it is perfectly proper for him to pay for it. Few hospitals could undertake such programs if they were required to bear the entire cost themselves. The fact that the patient did not himself elect the procedure is not particularly important. The hospital patient never picks and chooses the services he will receive from among all those offered at the hospital. This is done for him by the attending physician, who may then explain to the patient what is being done and why and how much it will cost. Precisely the same procedure may be followed in connection with routine Wassermann or chest x-ray tests. The patient will look to his doctor for an explanation of what is being done and why.

Where G.P. Fits In

Question: In a hospital medical staff composed predominantly of certified specialists, what is the rôle of the general practitioner?—J.P.R., N.C.

ANSWER: More and more hospitals today are organizing separate departments of general practice within the medical staff. Usually members of the general practice department of the staff confine their work to internal medicine, normal obstetrics, some minor surgery, and, of course, emergency surgery when necessary. The precise limits imposed on members of the general practice department in obstetrics and surgery vary from hospital to hospital. One hospital, for example, defines the work of the general practitioner as follows: "It is expected that the work of the general practitioner in the hospital will be in the fields of obstetrics and internal medicine. In obstetrics the general practitioner may apply low forceps and do an episiotomy where indicated; however, cases which require more complicated and extensive procedures than the above must be referred to a member of the obstetrical staff. In the field of internal medicine the general practitioner must call in consultation a member of the department of internal medicine on all cases which are not a good risk, with the case remaining under the supervision of the consultant until the danger point is passed."

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

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Illustrated above: Single Desk F-142-11.

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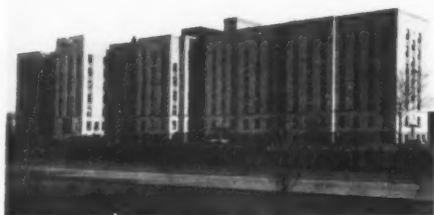
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OPERATING ROOM SAFETY

After a two-year investigation, experts of the U.S. Bureau of Mines have concluded that operating rooms and other anesthetizing areas in hospitals are frighteningly hazardous and that hospitals generally aren't too interested in preventing explosions.

Findings and conclusions, presented in formal but blunt phraseology, appear in a document titled "Static Electricity in Hospital Operating Suites and Direct and Related Hazards and Pertinent Remedies." For those who want to read all the documented evidence, the report may be obtained without cost by writing U.S. Bureau of Mines, 4800 Forbes Street, Pittsburgh 13. It was released in Washington by the Department of the Interior, under which the Bureau of Mines operates.

The Bureau of Mines was invited to make the survey because for years it has been active in investigating static electricity hazards and promoting safety measures in mines.

After testing equipment was purchased or constructed, the survey staff investigated 14 hospitals in central-eastern United States. Subsequently confidential questionnaires were sent to an additional 50 hospitals. Authors of the report are convinced these are a representative cross section of American hospitals.

The report rapidly comes to this conclusion: "There is probably no combination of equipment and personnel activity anywhere more liable to produce casual, dangerous charges of static electricity than that found at present in the anesthetizing areas of most hospitals. . . . The danger is real and should be considered seriously. To reduce the hazard to the minimum, major changes are needed in most hospitals."

Study of literature on the subject convinced bureau experts there has been no lack of factual information on operating room hazards. Why, then, haven't hospitals adopted more of the recognized safety measures? A number of reasons are advanced. First, many of the excellent papers on static electricity dangers probably were not circulated sufficiently to bring them to the attention of enough hospital administrators. Also, many of the recommended materials have not been available in adequate quantities. Even making allowance for these factors, authors of the report believe a large measure of responsibility must be placed on hospital administration. They declare: "It appears that very few hospitals have made a studied and continued effort to apply the remedies effectively. . . . Further reason for lack of application may have been that even though the needed materials could have been provided in greater quantity, the cost seemed prohibitive, and the prospect of tearing operating rooms and suites apart for installation was not pleasant to contemplate. No doubt the ratio of explosion casualties to those of other types or to total number of operations was regarded by many as not impressive."

As minimum protection, hospitals are urged to carry out the following 10 recommendations:

1. **Wool blankets, plastic sheets** and most of the usual synthetic fabric materials should not be used around anesthetic gas equipment or patients anesthetized with combustible gas mixtures.
2. **Conductive rubber mattresses**, pads and pillows should be substituted for the ordinary variety as soon as they are available. (Conductive substances pass on electricity before charges can be built up to the sparking point.)
3. **Conductive shoes** should be worn by all personnel working around combustible anesthetics or anesthetized patients.
4. **Conductive rubber breathing tubes**, masks and bags should be installed on existing anesthesia machines as soon as they can be obtained and should be standard equipment on all new machines.
5. **Conductive floors** should be installed in all operating and delivery rooms and in other rooms where combustible anesthetics are administered.
6. **Stools with smooth, rounded feet** and bare-metal tops are the most satisfactory and should be used.
7. **Nonconductive casters**, tires and stool-leg tips should be replaced by conductive rubber or other suitable material on all equipment in the danger areas.
8. **Outer garments of wool, silk or synthetic materials**, such as rayon, nylon, orlon, should be prohibited in anesthetizing locations.
9. **Receptacles and plugs** that cannot be pulled apart accidentally should be installed where needed.
10. **A suitable measuring instrument** should be installed in a convenient and safe place for testing the conductivity of shoes of all persons entering areas where explosive gaseous anesthetics are administered.

These recommendations are called "pertinent, practical and essential." The survey was directed by P. G. Guest, an electrical engineer; V. W. Sikora, a physical science aide, and Bernard Lewis, a physical chemist, all long-time employees of the Bureau of Mines.

CONSTRUCTION AND SUPPLIES

Federal hospital construction officials still are holding their ground against a proposed restriction which would vastly complicate hospital building. The proposal is virtually to eliminate the use of brass and copper in hospital specialty plumbing and equipment such as oxygen systems. So far, hospital officials have argued successfully that this type of brass and copper equipment is essential if a hospital is to meet modern standards. The subject came up at the last meeting of the National Production Authority's advisory

committee on construction, which finally tabled the plan—at least for the time being.

However, it's recognized now that copper and brass shortages are something that will have to be lived with for several more years. Allocations now are sufficient to meet about two-thirds of what are considered "worthy needs" of hospitals. Copper brass mill products present the most acute problem. Under some climatic conditions, galvanized steel may be used in place of these items, but in others the copper-brass fixtures are required.

General hospital supplies—professional furniture, operating room equipment, beds, instruments—still are available in necessary amounts, but a tightening situation is expected toward the end of the year. By then heavy purchasing by the military services and Civil Defense Administration will be eating into the normal civilian supplies.

If Congress follows President Truman's lead, it will appropriate money for construction and possible operation of hospitals under the community facilities provision of the Defense Housing Act. Although this was not covered in the regular budget, Mr. Truman has asked Congress to appropriate \$25,700,000 for hospital and health center construction and for providing recreational facilities. At this writing the figure has not been broken down as between health and recreation. To be eligible a community must officially be proclaimed as a critical defense area.

The Sterilizer Industry Advisory Committee of N.P.A. has been effecting economies in scarce nickel and copper through voluntary efforts. The committee is proud of its record—but it doesn't think the military departments deserve much credit for their showing. Urged on by the committee, manufacturers have been substituting monel metal for nickel-clad steel, stainless steel for monel or alloy castings for copper castings.

Meanwhile, according to the committee, the military is wasting stainless steel by requiring its use for sterilizer stands. Committee members said these specifications boost the cost of the unit, delay deliveries. Armed forces spokesmen claim the longer life expectancy of stainless steel justifies the extra expense. They also regard the \$70 saving on a stand supporting a \$1200 sterilizer as negligible.

PRICE NOTES

Price of surgical catgut sutures (absorbable sutures) will go up an average of about 7 per cent at both manufacturing and retail levels. The rise follows price increases allowed on raw material several months ago. . . . **Pharmaceutical** manufacturers are complaining about cost increases for labor and such items as **glass ampules** and **corrugated containers**, but they informed the Office of Price Stabilization that they were willing to remain under the general ceiling price regulation for the time being. They said current prices generally are at the legal ceilings, with the exception of some antibiotics, which are lower. . . . **Cast brass plumbing fixture** manufacturers report their price picture is seriously distorted both among products and companies. They probably will ask for an industry-wide price adjustment. . . . **Manufacturers of glass prescription ware** who have not raised their prices in more than a year and a half may adjust them upward to bring them in line with prices prevailing in the industry. O.P.S. acted to relieve several manufacturers who

voluntarily withheld scheduled price increases in January 1951, only to have their old prices frozen by the general price regulations.

OLD FOLKS FOR FREE

Speaking at the University of North Carolina, Federal Security Administrator Oscar Ewing made it plain he will continue to agitate for his plan of free-hospitalization-at-65. "We could," he said, "add this hospitalization benefit to social security by next year, and do it without any increase in the present wage deductions." Under the plan, all persons 65 or over who were entitled to social security benefits, plus certain categories of dependents, would be allowed 60 days of free hospitalization each year. Mr. Ewing announced the idea last June, saying then that legislation to put it into effect would be offered shortly. At this writing no bill on the subject has been offered in either House or Senate.

NATIONAL COMMISSION

Undeterred by criticism from American Medical Association and some congressmen, Dr. Paul Magnuson is moving rapidly ahead with his survey of the nation's health problems. His Commission on the Health Needs of the Nation, holding its second meeting in Washington, received a broad picture of what the federal government provides in the way of health programs.

Surgeon General Leonard A. Scheele explained what U.S. Public Health Service is contributing in the way of service to government employes and wards, and outlined some of P.H.S. efforts in research and control programs.

Fred A. McNamara, chief of the hospital section, Bureau of the Budget, told what government health programs were costing and discussed some of the financial problems.

Dr. Howard A. Rusk, whose committee advises Defense Department, Selective Service and Office of Defense Mobilization, discussed personnel health resources.

The commission, scheduled to complete its work in about a year, may start releasing some of its findings and conclusions before the entire task has been completed.

DOCTOR DRAFT

A dropping off in volunteering by Priority I physicians indicates that a showdown on the doctor draft law may come this spring, possibly in a month or so. Unless more young Priority I men join the reserves, Defense Department is prepared to ask Selective Service for the mandatory induction of several hundred of them. More than a year and a half after passage of the law, about 1000 Priority I men still have not joined the reserves. It is this group Defense Department and the Rusk committee want to get in uniform, before reserves are called from Priorities II and III.

Meanwhile, hospitals again are cautioned by Dr. Rusk's committee (National Advisory Committee to Selective Service) to select physicians for residencies in the reverse order of their priority standing. They are cautioned to accept none from Priority I, "except under very exceptional circumstances and probably in no instance except where there is a question of servicing an isolated community hospital."



LOOKING AROUND



Uphill Work

HOSPITAL PUBLIC RELATIONS is an art that is practiced by earnest, intelligent, articulate men and women who strive energetically to make people understand and like hospitals better, undaunted by the fact that the task is practically impossible on the face of it. Neither the warmest greeting nor the coolest logic can alter the basic circumstance that hospital patients are sick and their families are anxious and the whole experience is likely to take on the quality of an expensive nightmare. From distant Switzerland last month came evidence that even the initiate are victims of the fear that makes hospital public relations uphill work. "I wish that I may be granted to end my life at home and not in the hospital," Dr. Henry E. Sigerist, the great medical historian, wrote from his home in the Swiss countryside. "I have a horror of the hospital, that blend of penitentiary and third-class hotel," Dr. Sigerist said, displaying the kind of pique that hospital people are accustomed to encounter in strangers but may be jolted to find in a long-time member of the Johns Hopkins medical faculty.

"Of course, we need hospitals and we must be grateful that there are so many excellent ones," Dr. Sigerist grudgingly acknowledged. "Many examinations and treatments are impossible or at least very difficult outside of a hospital. But it is a dreary place, nevertheless, with its sterile-looking

rooms, bare walls, high beds, and the necessary but rigid routine that makes it so difficult to rest. The rooms are obviously not made to live in but to be treated in, and even the flowers that friends so kindly send us rarely succeed in brightening the room because they are no organic part of it and rather give it the appearance of a funeral parlor. How much nicer it is to be sick at home where we have our books, where the cat takes the place of a hot-water bottle, and where we may count on a decent cup of tea."

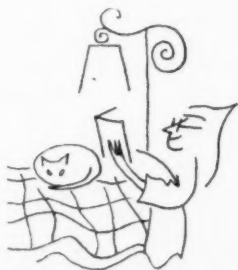
Hospital administrators and their public relations advisers can easily shrug this off as the carping of a cantankerous critic and comfort themselves with fond thoughts of pastel walls, chintz curtains, high-low beds and other innovations Dr. Sigerist doesn't know about. But they may be missing the point if they do. The point is that sickness and reason don't go together. The hospital patient sees and hears dimly, through a fog of anxiety which darkens the color, flat-

tens the taste, and gives the pleasantest words an ominous overtone. Like a frightened child who turns his face to the wall and remains inconsolable as distraught parents offer soothing gifts, the hospital patient turns his mind to the wall, and neither chintz nor cheer nor brightly written word will wholly win him back to light. Like healing and hospital administration, hospital public relations is a stern discipline, to be practiced successfully only by those whose perception is keen and whose faith is strong.

Three Steps Closer

IT IS AN ELOQUENT COMMENT on our society that Christ's simple admonition, "Do good," has become a term of opprobrium. Those who struggle toward distant, visionary goals, trying to do good in a practical world, are accustomed to being ignored, ridiculed and even hated for their pains. Eventually, they learn not to writhe when they meet the most frustrating of all responses to their strictures: "Yes, but this isn't the right time!"—the comfortable salve with which inaction eases its conscience.

Expecting only the hard boot of indifference or scorn, the do-gooder is thus understandably overjoyed to get an encouraging boost instead. As long-standing members of the Fuzzy Minded Idealists, Negro Medical Care Division, we were immeasurably cheered last month by three events which quickly erased the memory of



past discouragements. First, the Hospital Council of Greater New York published a report recommending that "All hospitals make available opportunities for staff appointments in ward and outpatient services and private patient privileges for Negro physicians for whom these opportunities are now limited." Hospitals exclusively for Negro physicians are not recommended, the council said.

Shortly after this report appeared, the New York County Medical Society approved a resolution deploring "discrimination against, or lack of opportunity for, the Negro doctor," and urging hospitals to extend staff privileges to qualified Negro physicians. At about the same time, the *Bulletin* of the Institute of Medicine of Chicago, a body of impeccable scientific standing, took troubled editorial note of the lack of professional justice for the Negro physician.

The goal is still distant, perhaps, but we have moved three steps closer to it, and the path is not as lonely as it has been. In a culture based on the teaching of Christ, exclusion of the Negro is surely a symptom of psychic weakness. A society professing to believe the dictum "Thou shalt love thy neighbor as thyself" but indulging in hatred instead, it seems to us, is a society that could fly apart at any time. If this is so, doing good is the only safe course to follow, and the idealist is the only truly practical man.

Wholly Roller

A HOSPITAL ADMINISTRATOR—by common acknowledgement one of the best in the business—was explaining the requirements of his job to a friend not long ago. "You really don't have to know so much," he said. "We have good people as department heads in nursing, food service, office management, purchasing, engineering and so on. They run the place.

"What I have to do mostly," the administrator went on, "is get along with the doctors and keep them happy, and get along with the trustees and keep them happy, and get along with the women's auxiliary and keep them happy. Actually," he concluded thoughtfully, "the job is just a dignified form of log rolling."

Lesson

IN PURSUIT OF a far-off literary goal, we had lunch the other day with the director of nursing at a large city hospital, a woman who turned out to be astonishingly relaxed, considering the size and nature of her responsibilities. For an hour or more, the conversation yawed aimlessly around, sometimes touching hospital and nursing subjects, sometimes veering as far off course as women's clothes and snow shoveling.

During one inshore tack, we asked our friend if she had a problem of student nurse recruitment at her hospital. Not particularly, she said: their



"We emphasize the fact that nursing is a good way to make a good living," our nurse said. "I can't understand why so many nursing and hospital people think nurses are underpaid. The fact is that they're well paid, compared to most other jobs. Girls who go to nursing schools are usually from families with modest or low incomes—otherwise they'd go to finishing schools or colleges, so it's these practical things that appeal to them."

We asked what she thought of nurse recruitment advertising generally. "Not much," she said. "There isn't any glamor to nursing, and girls who are attracted by glamorous advertising usually aren't the kind we want anyhow. They don't stick."

This kind of talk made sense, we thought. It was later in the conversation, however, that we decided we could accept, net, anything this nurse said. She'd been talking about her experience during the war, when, it turned out, she had been chief nurse at an army station hospital in the South Pacific.

"What was the most important

thing you learned in the army?" we asked, making like a reporter.

"I learned that the hospital where I worked before the war could get along without me," she replied.

Among Their Souvenirs

WE RAN ACROSS another reason hospital costs are always a jump or two ahead of income the other day when we were touring the new wing of a Midwest hospital. Handsome building, beautifully equipped. Our escort was demonstrating the inner workings of the overbed tables on the maternity division. She turned a knob one way—a mirror popped up. Turned it the other and a book rack moved into position. Suddenly she peered at the table, looking distressed but resigned: "Omgosh, there's another one gone."

"What's missing?" we asked, looking around helpfully.

"The tray that's supposed to be attached to this thing. They're the nicest little trays, just the right size for a refrigerator. I'll bet we've replaced a dozen since we opened this wing. The maternity patients love them—and walk off with them."

At these prices a little larceny should be thrown in free, the patients figure. This is charity?

Vexation

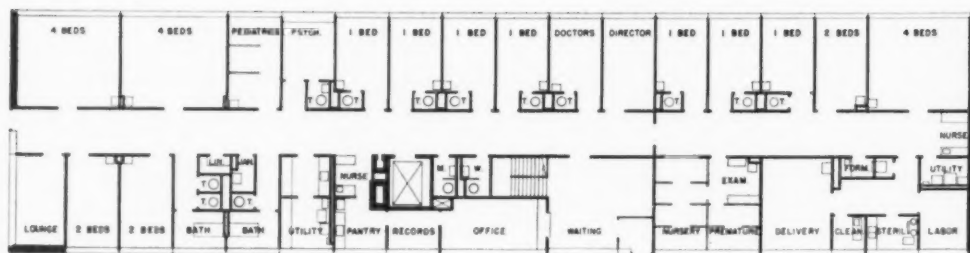
HE THAT INCREASETH KNOWLEDGE increaseth sorrow, saith the Preacher. A hospital we know about, straining for efficiency, had its new wing equipped throughout with reversible sash windows, so both sides could be washed from inside. Straining for beauty, the same hospital hired an interior decorating consultant who designed special valances for the windows in patients' rooms. When the valances were bolted in place, it turned out, the reversible sash wouldn't reverse. So while beauty and efficiency glare at each other from opposite sides of the new windows, the management can choose now between having the valances removed every time the windows are washed or having the window washers crawl around the outside of the building, the way they've always done. Behold, saith the Preacher, all is vanity and vexation of spirit.



THE MODERN HOSPITAL OF THE MONTH—SEE FOLLOWING PAGE

PLANNING FOR COMPLETE SERVICE

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FIRST FLOOR



GROUND FLOOR

The Modern Hospital of the Month

ROBERT W. CUTLER

Skidmore, Owings and Merrill
Architects—Engineers
New York City

The Edward John Noble Hospital at Alexandria Bay, N. Y., which is presented here, has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects and the state officials. A similar award will be made by *The Modern Hospital* each month.

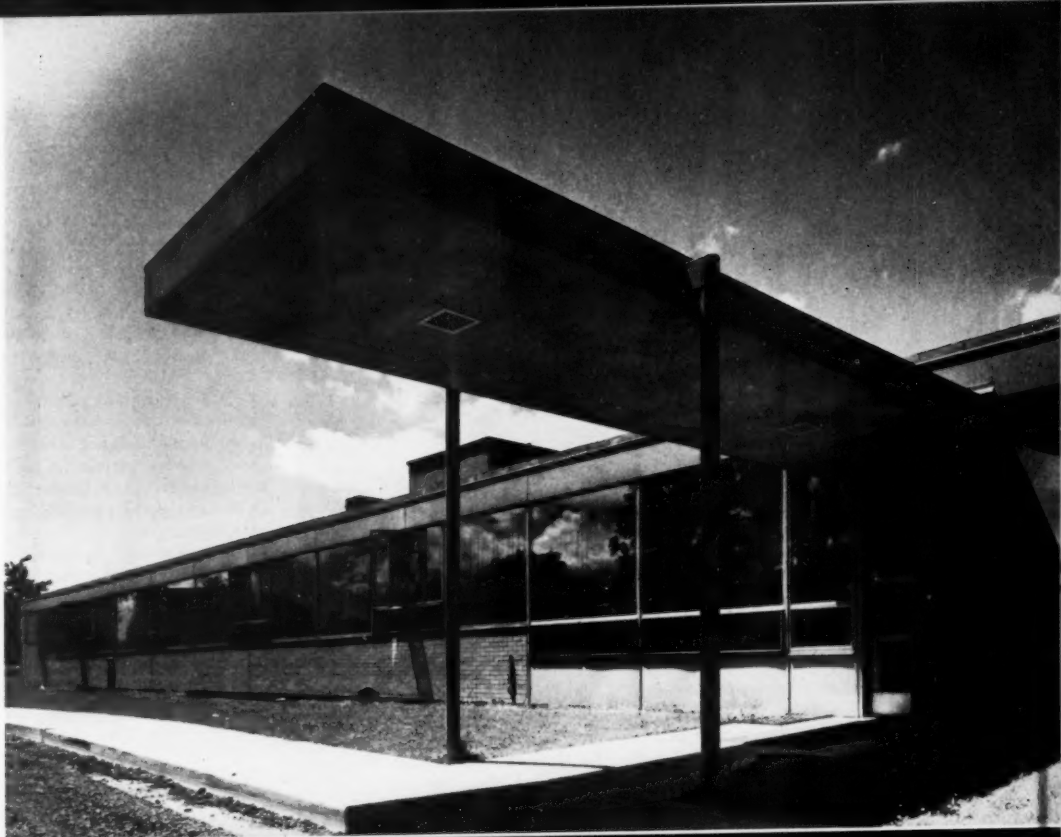
PROJECT COST (Including Group I and II Equipment) \$353,625
COST PER BED \$ 12,194

THE Edward John Noble Hospital at Alexandria Bay, N.Y., is one of three integrated hospitals comprising the North Country Hospitals (see October 1950 issue of *The MODERN HOSPITAL* for description of central hospital unit at Gouverneur). Smallest of the three, with 29 beds, it is planned as a complete unit with the exception of a laundry. Because it is a resort area the population of Alexandria Bay increases considerably during the summer months. This presented a problem of planning the hospital so that it would serve as an economical unit for the permanent population and yet be able to meet the expanded needs of the tourist population.

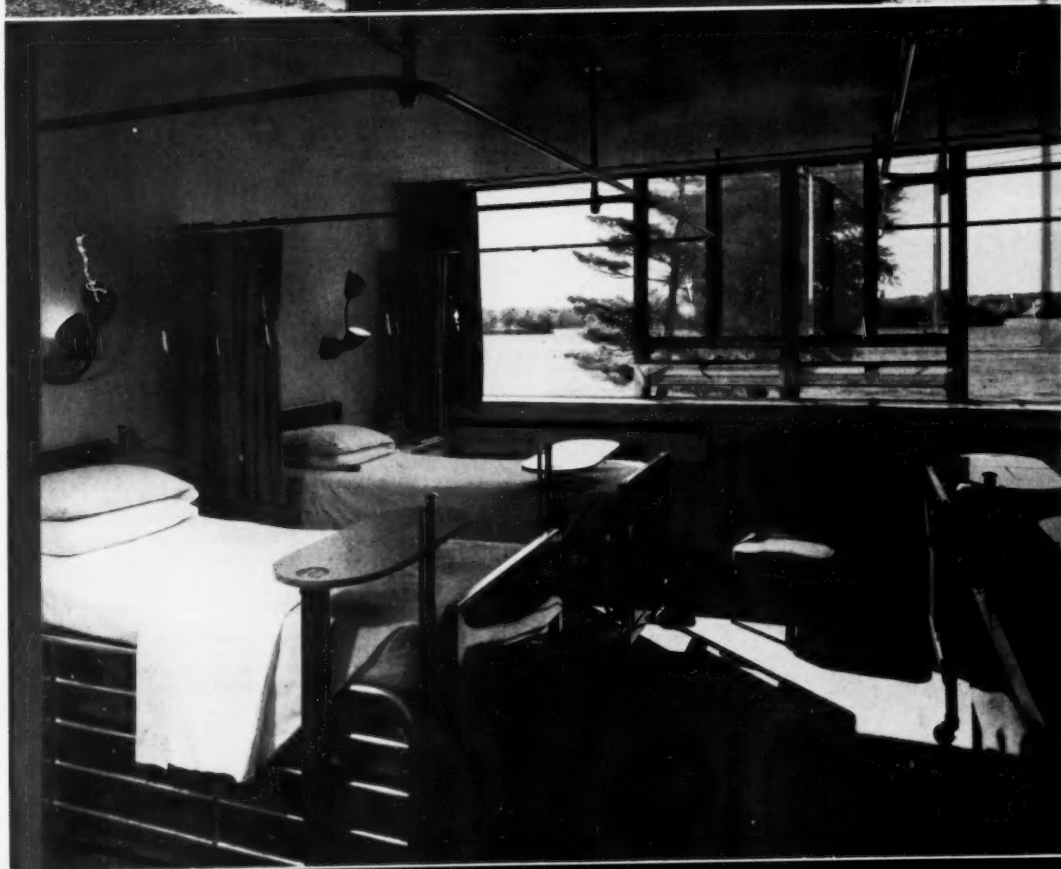
The hospital faces a magnificent view of the St. Lawrence River, the

The MODERN HOSPITAL

EXTERIOR IS OF LIGHT GRAY FACE BRICK BACKED WITH CINDER BLOCK.



MOST OF THE PATIENTS' ROOMS OVERLOOK THE ST. LAWRENCE RIVER.





Thousand Islands, and in the distance the International Bridge. Built within the excavation of the former Thousand Island House, a resort hotel which was destroyed by fire, it sits on a foundation of solid granite. Adequate parking facilities are provided, with ample room for expansion on the site. Adjacent to the site on the east is a public park which allows for a vast expanse of open space around the hospital.

The majority of the patients' rooms overlook the St. Lawrence River and Canada to the northwest. Whereas this exposure is not the best with relation to proper orientation, nevertheless the population has tremendous admiration

for the psychological and therapeutic effect of the river view. A patients' lounge is located on the southern corner of the building, with adjacent terrace planned to overlook the river. Facing away from the river on the patients' bed floor are utility spaces, administration offices, nurseries, and delivery suite. Because of a sloping site the portion of the lower floor toward the river was located above ground, allowing natural light and air in the kitchen, dining room, laboratory, sterile supply, and other work spaces. Storage spaces, boiler room, pharmacy, radiology suite, emergency and operating rooms are located on the side of the ground floor where

artificial light and ventilation are required.

As in other North Country Hospitals, the exterior is of light gray face brick backed with cinder block; continuous windows are glazed with double insulating window glass. The structural steel frame is unique; lally columns were used which are embedded in the partitions, producing a smooth wall surface with no projections. Open web steel joists support the floor and roof slabs, and are fire-proofed by vermiculite plaster ceilings. The lower floor is a concrete slab on grade. Interior finishes are generally plaster walls and asphalt tile floors, except in operating and delivery rooms which have glazed tile walls and terrazzo floors.

The building, while not air conditioned, is artificially ventilated, with separate zone controls and humidifiers to provide proper atmospheric conditions in operating and delivery rooms, nurseries, and so on. The elevator is oil hydraulic. A low pressure steam system is used for heating only, all sterilizers and kitchen equipment being electrically operated.

The program which resulted in the construction of this hospital was initiated by Edward John Noble who has a vital interest in the welfare of this community. The Edward John Noble Foundation of Greenwich, Conn., advanced a third of the monies necessary for construction costs; another third was raised from local contributions. The New York State Joint Hospital Survey and Planning Commission under the direction of Dr. John J. Bourke, and assisted by the Syracuse Regional Hospital Council, approved this project for Hill-Burton aid.

Mr. Noble's interest in this hospital, coupled with the energetic efforts of the local board under the chairmanship of Royal C. Garlock and the central board under the chairmanship of Albert E. Boughner, have brought readily accessible and completely up-to-date facilities for health protection to the residents of this section of northern New York. Their work in establishing this program gave the architects an excellent foundation for developing the plan and technical aspects of the hospital building.

Top of page: A patients' lounge is located on the southern corner of the building, with adjacent terrace overlooking the river. Bottom: The nurses' station commands the patients' corridor.



Special Services in the General Hospital

TUBERCULOSIS UNIT

CECILIA M. KNOX

Hospital Consultant
Division of Medical and Hospital Resources
Public Health Service

PETER N. JENSEN

Hospital Architect
Division of Hospital Facilities
Public Health Service

THE need to include adequate accommodations in general hospitals for the care of the tuberculous patient has long been recognized. Since 1908 practically all major national health organizations have recommended repeatedly and urged the allocation and construction of facilities in general hospitals for this purpose.

Response to these recommendations has been slow, but many states are currently projecting plans to meet the needs. The high cost of construction and lack of available funds have forced many to limit or curtail their plans. However, tuberculosis services are being integrated with general hospitals for purposes of providing centralized services and medical care. In some instances this includes the common use of facilities, medical consultants and other selected personnel for improved patient service and for education.

Of the 5031 short-term general and special nonfederal hospitals in the United States in 1950, having a total of 504,504 beds, only 269 hospitals, or 5.3 per cent, reported having tuberculosis facilities and services. The number of beds provided by these hospitals for tuberculosis patients was only 8615.

The number of beds and services required in general hospitals to meet current needs of tuberculosis patients and for solving health hazard problems associated with tuberculosis for the medical staff, hospital patients, personnel and others, and for the health of the nation is unknown. Certain recommendations from leaders in the field

should be recognized here, however. The Master Plan for Hospitals and Health Facilities for New York City recommends beds in general hospitals for tuberculous patients by size of hospitals as follows:

Size of Hospital	Recommended Tuberculosis Beds
755-955 (central hospitals)	50
585-785 (regional and community hospitals)	5-10

The Canadian Government Hospital Construction Program requires, by law, that 10 per cent of the beds in new general hospitals be allocated to the use of tuberculous patients.

The Committee on Sanatorium Standards of the American Trudeau Society recommends tuberculosis units in general hospitals in areas with low tuberculosis incidence and mortality rates, especially for areas requiring institutions of fewer than 50 beds.

When a hospital assumes a tuberculosis service it expands its functions as a community health agency. For purposes of this article these functions and related responsibilities may be summarized in three major categories:

1. To provide hospital and medical care for individuals in the community with known or questionable diagnosis of tuberculosis.

2. To serve as a barrier and specific unit in the control of tuberculosis in the community.

3. To contribute to the solution of socio-economic and welfare problems associated with tuberculosis, for the benefit of other health agencies, industry, conservation of manpower, the patient, and his family.

Plans for any health facility are dependent upon the program of service for which the facility is being provided, following analysis of needs and resources within the respective community.

The plan presented here for a 20 bed nursing unit is adapted from "A Twenty-Five Bed General Nursing Unit." It illustrates physical facilities required for medical and nursing services for the care of male and female adult tuberculous patients in the average general hospital of about 200 beds.

Although patients admitted to this unit will have long-term and chronic illnesses, hospitalization periods in this unit for the majority will be of short duration, ranging from several days to several weeks. A few may remain for longer periods. Some will be acutely and seriously ill and will require special and continuous nursing care for surgical management and other reasons. A few will have ambulatory privileges to varying degrees and will require a minimum amount of direct nursing care.

Sources and types of patients admitted to this unit will probably include:

1. Those with known or suspected tuberculosis on initial admission.

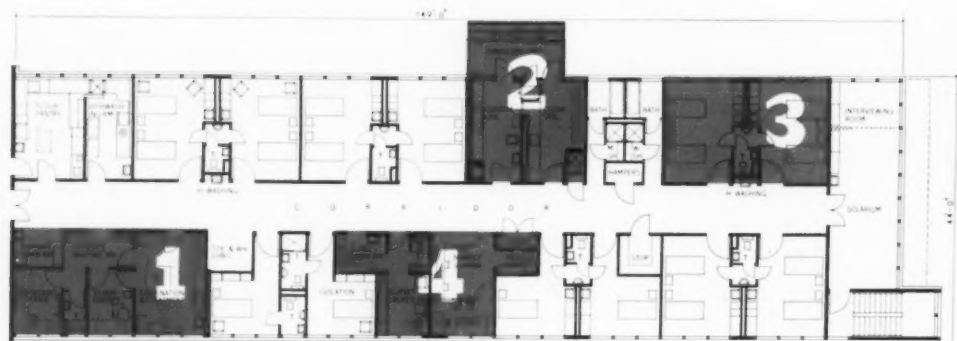
2. Patients with post-admission diagnosis of (or suspected as having) tuberculosis, transferred from other nursing units in the hospital.

3. Tuberculosis patients from special hospitals and sanatoriums who are in need of definitive surgical treatment and management that require facilities, equipment and services provided in the general hospital.

4. Outpatients who require follow-up work, observation and treatment related to tuberculosis.

5. Patients waiting for a bed in a tuberculosis hospital or sanatorium.

The authors and editors wish to acknowledge the assistance and consultation given by staff members of the National Tuberculosis Association; individual hospitals; consultants in the Public Health Service, Division of Chronic Diseases and Tuberculosis, and others whose cooperation in the development of these plans is deeply appreciated.

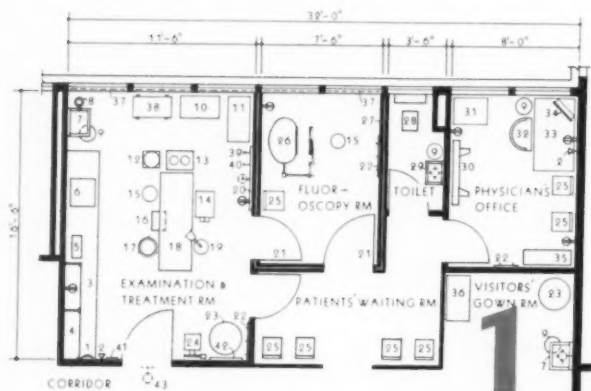


20-BED TUBERCULOSIS NURSING UNIT FOR A GENERAL HOSPITAL

PRIVATE AND SEMI-PRIVATE ROOMS WITH CONNECTING TOILETS, TWO-BED BAY

2" = 6'-0"

TOTAL AREA 4,650 SQUARE FEET
AREA PER BED 232.5 SQUARE FEET



EXAMINATION AND TREATMENT ROOM, FLUOROSCOPY ROOM, PHYSICIAN'S OFFICE, PATIENTS' WAITING ROOM AND VISITORS' GOWN ROOM

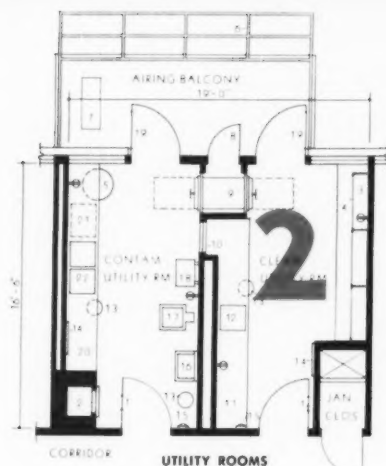


KEY TO PLAN

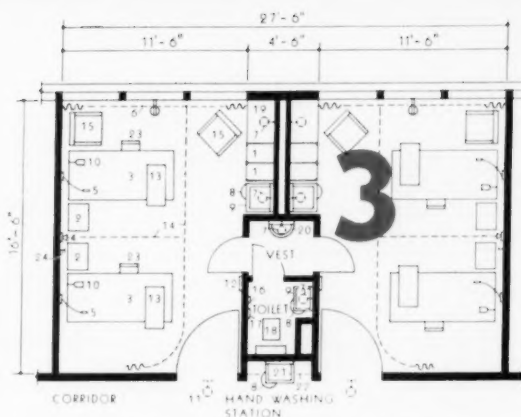
1. Domelight and buzzer set, 5 feet 6 inches from floor
2. Telephone outlet
3. Counter, 36 inches high, with cabinets below
4. Wall cabinet
5. Instrument sterilizer, 17 1/2 by 7 1/2 by 6 inches
6. Built-in instrument sink, with gooseneck spout and foot or knee control
7. Scrub sink with gooseneck spout and foot or knee control
8. Soap dispenser, single, with foot control
9. Waste paper receptacle
10. Clean-up table, 18 by 30 inches
11. Instrument table, 18 by 33 inches
12. Single basin stand
13. Pneumothorax apparatus with stand
14. Mayo table
15. Adjustable stool
16. Footstool
17. Kick bucket
18. Examination table
19. Examination light
20. Film illuminator, 2 units of 3 each, built-in
21. Lead-lined door
22. Hook strip
23. Laundry hamper
24. Clinical scale
25. Straight chair
26. Fluoroscope
27. Lead-lined walls
28. Water closet
29. Lavatory with gooseneck spout and foot or knee control
30. Mobile film illuminator stand
31. Film file
32. Desk chair
33. Executive desk
34. View box
35. Bookcase
36. Table for clean gowns
37. Lightproof shades
38. Dressing cart
39. Suction outlet, 5 feet 6 inches from floor
40. Oxygen outlet, 5 feet 6 inches from floor
41. Nurses' call (connected to nurses' station)
42. Bulletin board, 26 by 24 inches
43. Corridor domelight

Room elements, facilities and special arrangements included in this plan are based on (1) a health program for all-inclusive medical and nursing care, for individual needs of patients, including trends in medical practice for prescribing greater activity than formerly for selected tuberculous patients, and (2) current standards for control of tuberculosis.

Facilities supportive to the program and included in this plan are: a unit equipped for medical observation, examination, treatment and diagnostic purposes; a self-contained room for isolation and care of selected patients; dishwashing room and floor pantry designed and equipped for recommended practices for "safety" in the management of food and dishwashing; utility room with incinerator for effective disposal of contaminated materials, and autoclave for sterilization of utensils; gown rooms for visitors and nursing personnel; lavatories with gooseneck spouts and foot or knee control located in patient rooms, corridors, alcoves and elsewhere in the nursing unit convenient to patients and personnel for "adequate hand-washing"; office and conference rooms for private interviews and conferences with patients and their families; a solarium for leisure occupations and health education activities for ambulatory patients; and patient rooms equipped for privacy, convenience, comfort and happiness of patients and supportive to economical and effective nursing service. Facilities and services not contained in this unit may be required occasionally for a limited num-



- KEY TO PLAN**
1. Vision panel
 2. Incinerator
 3. Wall cabinet
 4. Counter, 36 inches high, with cabinets below
 5. Laundry hamper
 6. Mattress airing rack
 7. Drying rack
 8. Access door
 9. Sterilizer with double doors, 24 by 36 inches
 10. Pass window
 11. Counter, 36 inches high, with open shelf below
 12. Sink in counter
 13. Waste paper receptacle
 14. Bulletin board, 26 by 24 inches
 15. Domelight and buzzer set, 5 feet 6 inches from floor
 16. Scrub sink with gooseneck spout and foot air knee control
 17. Clinical sink
 18. Hat plate, double element, on bracket
 19. Glazed door
 20. Counter, 36 inches high with open shelf below
 21. Cracked ice bin (for external use only)
 22. Built-in double compartment sink



TYPICAL SEMI-PRIVATE ROOMS WITH CONNECTING TOILET

- KEY TO PLAN**
1. Built-in locker
 2. Bedside table
 3. Adjustable hospital bed
 4. Telephone outlet and duplex receptacle
 5. Nurses' calling station with duplex receptacle
 6. Sliding window curtain
 7. Wall bracket light, switch controlled
 8. Waste paper receptacle
 9. Lavatory with gooseneck spout and knee or elbow control
 10. Bed light
 11. Corridor dome light
 12. Night light, switch controlled
 13. Overbed table
 14. Cubicle rod and curtain
 15. Easy chair
 16. Nurses' calling station (push button type)
 17. Grab rail
 18. Water closet with bedpan lugs and bedpan flushing attachment
 19. Built-in dresser
 20. Dental lavatory
 21. Scrub-sink with gooseneck spout and knee or foot control
 22. Shelf above scrub sink
 23. Straight chair
 24. Oxygen and suction outlets, 5 feet 6 inches from floor

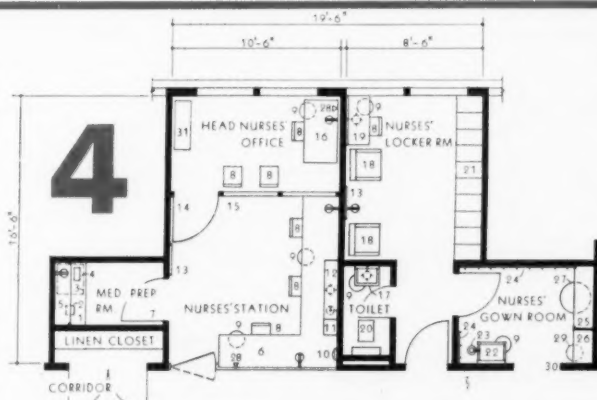
ber of patients, such as those for physical medicine and prevocational rehabilitation. It is assumed that these are provided elsewhere in the hospital.

Hospital services used in common by other nursing units will provide service to this nursing unit, such as (1) central sterilizing and supply; (2) clinical laboratory, diagnostic and therapeutic; (3) laundry; (4) pharmacy, and (5) kitchen.

The major objective in planning a nursing unit is to provide effective and safe care to patients. In this plan the nurses' station and certain service areas of the unit are grouped and located centrally. This is in keeping with the demands for supervision, control, accessibility to frequently used areas and facilities and for over-all management of the unit in relation to patient rooms.

Patient Accommodations

Patient rooms provided in this plan include eight semiprivate (2 bed bay) and four single rooms, including one for isolation. Facilities included in patient rooms and their arrangement are similar to Plan A, for the "Twenty-Five



NURSES' GOWN ROOM, NURSES' LOCKER ROOM, NURSES' STATION, OFFICE AND MEDICINE PREPARATION ROOM

- KEY TO PLAN**
1. Counter 36 inches high
 2. Medicine sink in counter
 3. Refrigerator under counter
 4. Instrument sterilizer
 5. Wall cabinet
 6. Counter, 30 inches high
 7. Dutch door with lock
 8. Straight chair
 9. Waste paper receptacle
 10. Domelight and buzzer set
 11. Pigeon-hole form rack
 12. Chart rack
 13. Bulletin board
 14. Glazed door
 15. Glazed partition
 16. Desk
 17. Lavatory
 18. Easy chair
 19. Counter with mirror above
 20. Water closet
 21. Lockers, full length
 22. Scrub sink
 23. Soap dispenser
 24. Hook strip
 25. Wall cabinet
 26. Shelf for clean mask container and forceps jar, mirror above shelf
 27. Laundry hamper
 28. Telephone outlet
 29. Receptacle for contaminated masks
 30. Trimmed opening

Bed General Nursing Unit," with the addition of oxygen and suction outlets, and dental lavatory located in connecting vestibules. Special features of these rooms are: built-in lockers and dressers to provide space for individual patients' belongings; lavatories in connecting toilets and in patient rooms; space around beds is ample to accommodate use of special equipment and provides adequate working area.

Separate bathing facilities, including shower and tub, are provided for male and female patients, in a centrally located unit.

Nurses' Station

In any nursing unit practically all activities gravitate from or toward the nurses' station.

Space and equipment allocated to the nurses' station are planned to accommodate desk work of three people simultaneously. Included in the nurses' station are counter chart desks on two sides of the room with attached chart racks; compartments for forms and miscellaneous materials required for clinical records and management of the unit; chairs; nurse-patient communicator or call board and buzzer system; ceiling and desk lamps; wall clock; bulletin board, and telephone.

Head Nurse's Office

Allocation of space for a separate room designated as the head nurse's office provides a much needed combination office and conference room for the convenient use of the nursing staff. Space allocated to the head nurse's office accommodates furniture required for activities inherent in ward management: planning, administration of the nursing unit, use of nurses' ward library, private and group conferences, in-service staff education, and planning patient care.

The nurse's office adjoins the nurses' station. This provides privacy and exclusion of distraction, disturbance and interruptions; it allows for accessibility to the head nurse and permits her to retain supervisory control over the unit at all times.

Orientation of this room for natural daylight and partitioning it from the nurses' station with a glazed partition provides natural daylight to both rooms.

Medicine Room

The medicine room adjoins the nurses' station. The design of this

room and facilities provided are similar to those in the plan for the "Twenty-Five Bed General Nursing Unit," except that a Dutch door with lock is featured in this plan.

Nurses' Facilities

The availability of locker and rest-room facilities elsewhere in the hospital for nurses from the tuberculosis nursing unit would eliminate the need to provide such facilities in this unit. Space thus released could then be allocated to room elements not included here, such as a flower room or much needed storage space.

Examination and Treatment

Routine medical care of tuberculous patients requires certain facilities and equipment which are not needed to the same degree for general medical-surgical patients. These are the facilities and equipment essential to medical examination, diagnosis and therapy peculiar to medical supervision and planning of tuberculosis programs of care. In addition to supporting the total program of patient care, inclusion of these facilities minimizes traffic from the unit to the general radiographic department, provides convenience to patients, and conserves their energy and strength.

Facilities provided include a combination examination and treatment room with suction and oxygen outlets, instrument sink and sterilizer, scrub sink with gooseneck spout and foot or knee control, and a built-in film illuminator. The room is designed to accommodate common usage for medical and nursing functions. Included also are adjoining fluoroscopy room, physician's office, toilet and lavatory room and a waiting room for ambulatory or stretcher patients.

Utility Room

One of the special features of the utility room area, as designed for this nursing unit, is a separating wall that divides the area into two rooms to maintain control of contamination and infection.

Other features include an incinerator in the contaminated utility room for safe disposal and minimal handling of contaminated material; a double door autoclave connecting both utility rooms (this does not preclude the use of central sterilizing services in the hospital); an airing balcony with airing racks (mattress and other) and accessible from both rooms; built-in

double compartment and clinical sinks in the contaminated room. An ice chest is located under the counter in the contaminated room. This is intended for ice used in ice collars and the like, since ice required for drinking purposes, medications and dietary needs is located in the floor pantry.

Linen Room

Space for storage of linen in this nursing unit is based on the unit exchange system and the practice of keeping reserve linen in the hospital's central linen room. It is intended for current linen needs including emergencies.

The linen closet is designed for permanent shelves.

Janitor's Closet

This room is centrally located and is intended to accommodate limited supplies required for housekeeping activities in this unit. Since scrupulous housekeeping and sanitation are mandatory to the control of tuberculosis this space must be adequate for constant availability of clean equipment.

Hamper Alcove

Recommendations for the management and handling of soiled linens have been formulated by authorities in the field of tuberculosis. These include collection procedures, identification of laundry bags and others. Space is provided in this nursing unit for storage and availability of clean hampers to be used in accord with those recommended.

Visitors' Gown Room

The need to include a visitors' gown and cloak room in the nursing unit is dependent upon medical and nursing staff practices established for the control of infection, including protection of visitors. These practices may include removal of coats before entering patients' rooms, and the use of masks and gowns by visitors in this unit. Location of the visitors' gown and cloak room is dependent upon supervisory needs and availability of personnel for safeguarding visitors' belongings.

Included in the visitors' gown room contained in this nursing unit are: scrub sink with gooseneck spout and foot or knee control, receptacle for disposal of towels, laundry hamper, table for supply of clean gowns and masks. Wall space provides for a hook strip for visitors' coats.

Special Services in the General Hospital

NEUROPSYCHIATRIC UNIT

THERE are many points of view relative to nervous disorders and proper facilities in which to hospitalize the individual having an ailment which affects the nervous system. As a layman and planner it seems consistent to consider views that relate to planning and building workable hospitals, oriented to patients' medical needs, designed to help meet the individual's need for emotional and psychic comfort in the hospital. We realize that the hospital building is but a part of the facility and that it is the human personnel which provides much of the patient's environment; but the hospital's structure and personality are the planner's responsibility in a major degree.

SUFFERS MEDICAL ILLNESS

A substantial number of medical men and administrators, at least, hold that the individual having a disorder which affects the nervous system is suffering a medical illness. For the planner this idea at least offers clarification of a subject that has not in all ways been clear and enables him more readily to comprehend the problems and objectives in hospitals with which he works and plans. The patient's care and treatment (happily!) repose in the hospitals and doctors. But the planner at least should be sure about what he is working with and what is the desired ultimate objective. This objective naturally would be that the patient be relieved of the ill as promptly and pleasantly as practicable and then discharged from the hospital to return to a normal mode of existence. The question is what can the

Appreciation is expressed to the doctors and administrators who helped me to shape this commentary and for the generous amount of time and patience given in discussion, criticism and suggestions.

GEORGE BLUMENAUER

Architect
Hospital Planning Consultant
Kansas City, Mo.

general hospital do about this situation? How can the general hospital be planned or remodeled to hospitalize and treat nervous and mental patients?

Published figures mention the number of persons committed to public institutions in the several states for custodial care or treatment for nervous disorders, classified somewhat loosely in legalistic language as insanity, lunacy or mental illness. The statistics do not in all ways provide a clear picture. Obviously the figures include the host of repeaters in chronic alcoholic and drug addiction categories and other types of readmittals; and individuals in upper-age groups who are in normal state but whose families had them committed in order to be rid of them; individuals who get into legal difficulties and obtain commitment to a mental institution in preference to serving a term in a penitentiary; congenital defectives, and many psychoneurotics who should not be hospitalized but may need help or counsel.

A question is why should so large a proportion of individuals who suffer from a disorder that affects the nervous system (and what medical illness does not have its impact on the nervous system?) be neglected until malignant symptoms appear or serious deterioration is apparent? The answer in part might run somewhat as follows: Who voluntarily chooses to go to the asylum and, if he is ever released, carry its stigma thereafter; to become an incompetent ward of government; to leave home, friends, work or business, with loss of legal rights and normal prestige as an individual? Few so

choose. Who would not dread to go to the "asylum"? Often proper care and treatment of the afflicted person come too late or are not of a kind to restore the patient to good health and the probability of a normal existence.

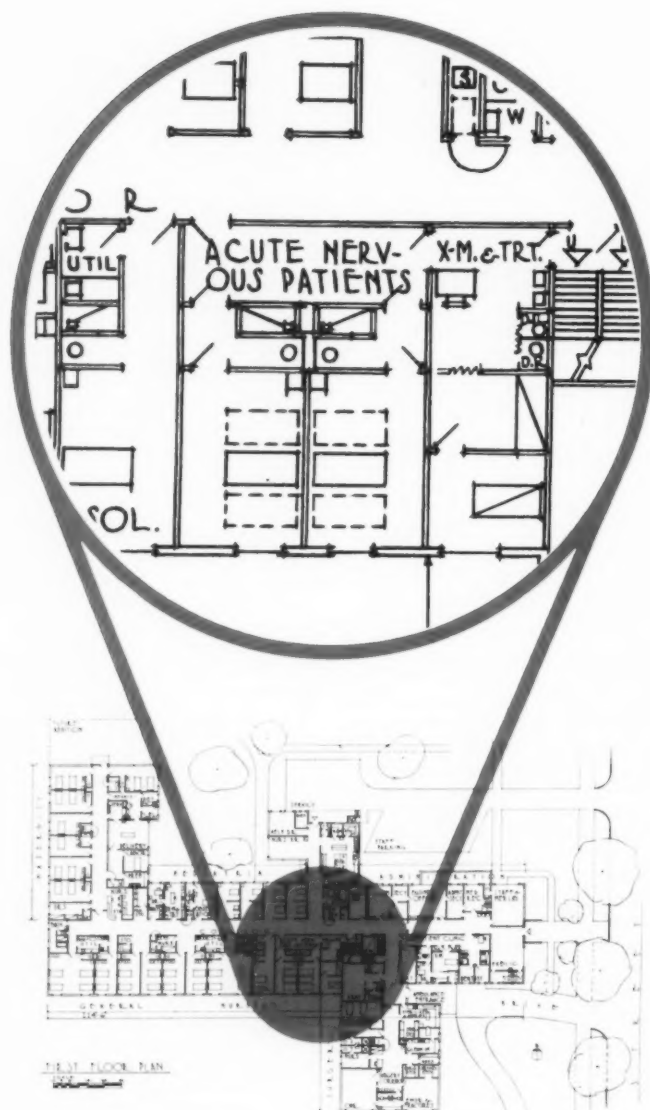
If the desirability of an ultimate goal that the psychiatric hospital as a special institution should disappear from society is accepted, there must come in evidence a workable, economical alternative. This alternative seems to lie in the conditioning of the community general hospital and planning of new ones to hospitalize nervous and mental patients in their home communities, so far as practicable. The percentage of persons so afflicted, when analyzed on the community level, is not formidable or especially out of proportion to the number of persons suffering other medical ills; this seems especially true if we except alcoholics, drug addicts, and congenital defectives.

NOT TOO DIFFICULT

To judge from material published on the subject, a belief exists among a substantial percentage of medical men and administrators that to deal with acute nervous disorders in the early stage of the affliction should not present greater difficulties in the properly planned and oriented general hospital than are met in dealing with the average typhoid, peptic ulcer, obstetric or other patients, and that the average of such patients can be discharged from the hospital and returned home after from two to six weeks of proper care, treatment and counsel, like patients having other acute ailments. Those needing a longer stay in the hospital or for convalescence would be kept under observation.

To subject the acute patient to a

The plan at top is an enlargement of the nervous and mental unit incorporated in the design of a small general hospital.



behavior, and the undesirability of mass procedures in the hospital is self-evident. How to avoid it is another matter. For the mass of people to think of a nervous disorder as a mysterious affliction, dichotomized from the functions of the organs, glands, muscles and bones, the nervous system and metabolism, seems inconsistent. Administrators and planners who indulge the fantasy of dichotomy of mind and body may be in error.

The public mental disease institution, perhaps of necessity, has been based primarily on a custodial principle; an individual committed by a court for insanity usually is first taken to jail and then to the institution by officers of the law—not infrequently manacled—and also meets a number of psychological hazards in addition to restraint and the treatment. These hazards the afflicted person may be ill-prepared to cope with either during incarceration in the institution or thereafter, and an "asylum label" is an almost insurmountable obstacle for the individual.

There are sound reasons favoring the orientation of the community general hospital so that it can promptly hospitalize the individual suffering an acute nervous disorder. Among other reasons would be the over-all cost of building and operating hospitals; the annual cost per capita for public "mental hospitals" does not grow less. There also is the question of emotional tone in the patient for which it is difficult to find a solution in the impersonal mass procedures of a mental hospital, and it cannot be converted into a general hospital. There also are the questions of psychic comfort and the emotional difficulties experienced by the average committed patient which result from enforced confinement, frustration and segregation from normal activities and the world which the individual grew to know and understand. All of which point to the milieu and services which may exist in the local community hospital. Without excessive remodeling of facilities and routine, an existing general hospital usually can afford proper care and treatment—including the patient's isolation from relatives and friends as

much longer period in the hospital—particularly one of the institutional kind—tends toward breakdown of the patient's morale and deterioration of the individual, which is a premise supported by substantial factual record; thus prompt care and treatment for the afflicted person are desirable, as in other kinds of medical ills, and where can such care be obtained so

promptly and conveniently as in the local community hospital? In the case of deteriorated individuals, or those having malignant symptoms, the examining physician in the hospital naturally would judge if the patient's condition would be amenable to the general hospital's routine and facilities.

Human beings are individuals; they have individual emotions, thought and

need be—and other technics, and a staff of competent doctors.

In comparing advantages and disadvantages and relative cost of commitment of the acute patient in an institution for an indeterminate period, as against hospitalizing the individual in the local general hospital for care and treatment, there seems much to be said favoring payments from public funds to the general hospital for the patient's care if necessary. The cost of hospitalizing indigent persons, and some not so indigent, at public expense is generally accepted. In normal times the average general hospital usually will have a few vacant beds available for prospective patients.

There is the question as to whether orienting the general hospital as a matter-of-fact facility in the community is not both essential and desirable. That rare phenomenon called "perfection" seems a far-off target at which to aim, but we see the standards by which to judge comparative degrees of achievement and we assume that the primary objective of the hospitalization is to mitigate hardship and deterioration in individuals who, for one reason or another, suffer an acute nervous ailment.

The record indicates that the average patient suffering an acute nervous disorder should cause no more trouble or disturbance in the properly planned and oriented general hospital than would the average of other acutely ill patients, and the hospital should experience no undue hardship in dealing with the occasional patient who undergoes a period of increased psychomotor activity. A physical therapy unit is needed for this type of patient. It should include at least hydro and vapor baths, electrotherapy and massage and be so planned in the hospital that it also may serve other types of patients including outpatients.

Noise control is essential. Excessive auditory stimulation is detrimental to health and a good mood and may become lethal. Under the stress or tension of nervous disorder the individual's emotions tend to be too readily relaxed and the planner should strive to create a congruous environment wherein the patient may feel at ease. This type of patient normally will require a longer period in the hospital than the median stay of other acute patients and usually will be ambulatory.

In addition to noise control, the proper color in the decoration and

furnishings will engender and maintain a good mood in both patients and personnel and encourage the patient's urge toward recovery. And where can the planner find color schemes for hospitals which equal those to be found in nature itself? It is well known to medical men that a suitable environment, conjunctive with other hospital procedures, is beneficial to the patient and helps to speed recovery from depletion of vital forces in the nervous system.

Patients react to color, and incongruous colors and designs in the environment may have an ill effect on individuals, possibly eventually resulting in illness. Color schemes of interiors and exteriors may be studied with fairly definite results in mind, and color generally may be expected to affect normally healthy individuals somewhat as follows: Red produces immediate stimulation followed by a nervousness and tends to cause inaccurate judgment regarding time, weight and distance. Blue is quieting, a color to be used with caution in

hospitals for it may become depressive. Yellow engenders cheerfulness, light and a feeling of greater space; it fosters amiability and aids intellectual efficiency. Green is a predominating color in nature and especially useful in giving quality and tone to other color tones; it engenders restfulness and increased vitality. Black is depressing; it absorbs heat, light and sound. White is a strong color; it tends to tire the eyes and is especially useful in toning down the primary colors to lighter hues.

The schematic layouts shown of a small general hospital are economical and workable. The plan calls for 42 beds which may be expanded to a 70 bed hospital by addition, a second story covering a portion of the plan, and a moderate amount of replanning. It is shown for the reason that it would provide beds, treatment facilities and space for temporary isolation at need for from two to four patients. It has a physical therapy department and a department where outpatients can be examined and a pediatric unit.

Ceiling-Hung Tube Expedites X-Ray Service

DESIGNED to expedite use of modern high frequency x-ray technic, the new ceiling-hung tube stand installed in the Illinois Masonic Hospital, Chicago, is a 500 milliampere unit with 125 KV rating, using a super-dynamax tube.

Operating on the same principle as an overhead crane, the new tube stand allows the operators greater flexibility of action. Getting the tube stand off

the floor permits operators and physicians to work on both sides of the patient.

A high voltage unit, the machine produces film with greater density and less contrast, requiring new technics of interpretation. The unit is complete with automatic photo timing. The patient stands up against the cassette changer, while the device automatically selects proper exposure time and KV regardless of the thickness of the patient; this eliminates errors which formerly crept in under the older thickness per part technic. Exposure ranges are from one-sixtieth of a second to 14 seconds, depending upon the circumstances.

This installation is believed to be the first in the Chicago area; actually, there are only four or five others in the United States. Part of an expanded x-ray department set up in the new wing of the Illinois Masonic Hospital, this development is just one step in a long-range expansion program currently being undertaken by the Illinois Masonic Hospital Association under the guidance of Congressman Edgar A. Jonas, president of the board, and William H. Tenney, hospital superintendent.—EDMUND MOTTERSHEAD.



X-ray machine at Illinois Masonic.

Special Services in the General Hospital

CONVALESCENT UNIT

THE Jenks Convalescent Building at the Huntington Memorial Hospital, Pasadena, Calif., was built solely to serve convalescent patients and was planned that way from the ground up. The building has exploited to the full the climatic advantages of a subtropical region by making the closest possible integration of indoors and outdoors. It is a "garden hospital" to the greatest practicable extent. Also, this is perhaps the most complicated building in plan and use in which tilt-up, precast construction has been used.

The trustees, with at first lukewarm and later wholehearted support from the medical staff, decided that the new unit should be a convalescent building because they thought that this would give considerable relief to the overcrowded acute hospital and might make interesting hospital history. The architects entered into the project with enthusiasm, as the head of the firm, William L. Pereira, had already devoted a great deal of study to the convalescent problem and was heartily in favor of such units to bridge the gap between the acute disease hospital and either the home or a home substitute.

After many alternatives were sketched, the present basic design was chosen enthusiastically by the trustees. It was first planned to be built of masonry construction but, as the program developed, two members of the hospital building committee felt that greater earthquake resistance and better quality could be obtained at no greater cost by making it of precast concrete tilt-up construction. Accordingly, the architects reengineered and redesigned the entire building.

Most hospitals with convalescent fa-

At the time this article was written Mr. Mills was administrator of Huntington Memorial Hospital, Pasadena.

ALDEN B. MILLS

Director
Mountainside Hospital
Montclair, N.J.

PEREIRA and LUCKMAN

Architects and Engineers
Los Angeles

cilities have contented themselves with using remodeled houses or older hospital buildings. In the new Pasadena institution, however, an entirely new, "Y" shaped design was worked out solely for the purpose of convalescent care. This enabled the architect and the hospital to have a free hand to incorporate in the building many features which others would like but were unable to provide.

Most notable of these is the fact that every room in the building is on the ground or garden floor and each has a large sliding door through which the beds can be wheeled out into the garden area. Through the use of a "Y" design with the patients' rooms set at an angle from the central corridor, it was possible to give each room its own private patio separated from the adjoining room by an attractive planting box and to provide ample light and air.

Another unusual feature of the building is the commodious and handsome dining room-lounge where patients who are up and about can read, play games or just talk about their operations!

As has become standard practice in many hospitals, every patient's room is provided with lavatory and wash basin. In addition, there is a pair of bath facilities, one shower and one tub, for each set of eight patients' rooms.

The nurses' station located at the center of the "Y" is of a modern and

attractive design and permits the ward clerk who will sit at the desk to have full view up and down the corridors, as well as a view of the waiting alcove and the entrance, and provides good space for doctors and nurses to do necessary writing in the patients' medical charts. Behind the nurses' station is a locker room and toilet for the nurses and a commodious medicine room for careful preparation of any medication.

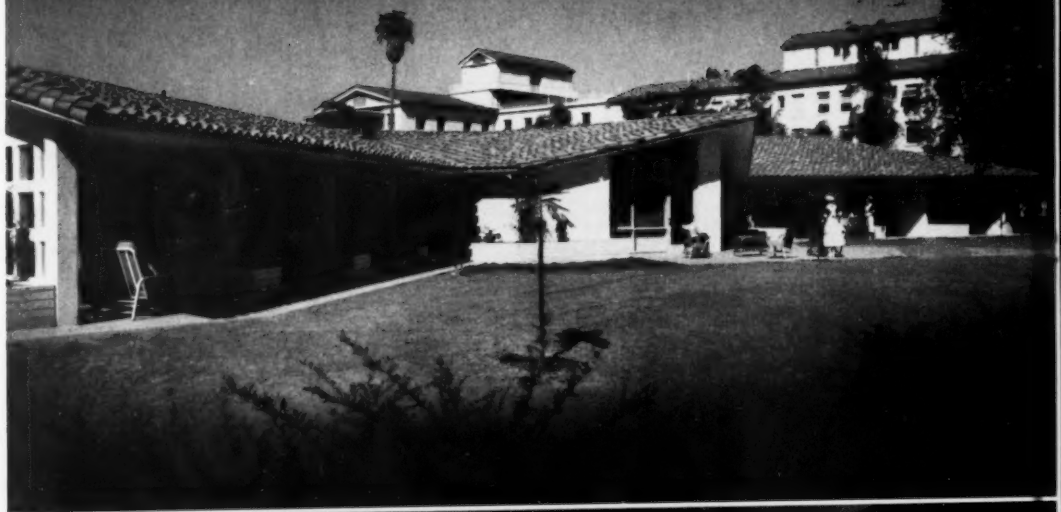
The linen room in the new building is sufficiently large so that a cart loaded with clean linen can be wheeled in and left there until the following day when another cart-load of clean linen comes and the empty cart is returned to the laundry.

Because Huntington Memorial Hospital is a teaching institution and both professional and practical nurses will receive some of their instruction at the new building, a separate conference room has been provided where this teaching may be carried on without undue interruption. This room may be used furthermore for conferences among the doctors or by physicians with members of the patients' families.

In addition to acting as a social center and a place where occupational therapy can be carried on, the dining room-lounge constitutes a substantial addition to the emergency facilities of the hospital as it could in case of a serious situation be used as emergency ward and has toilets and floor pantry

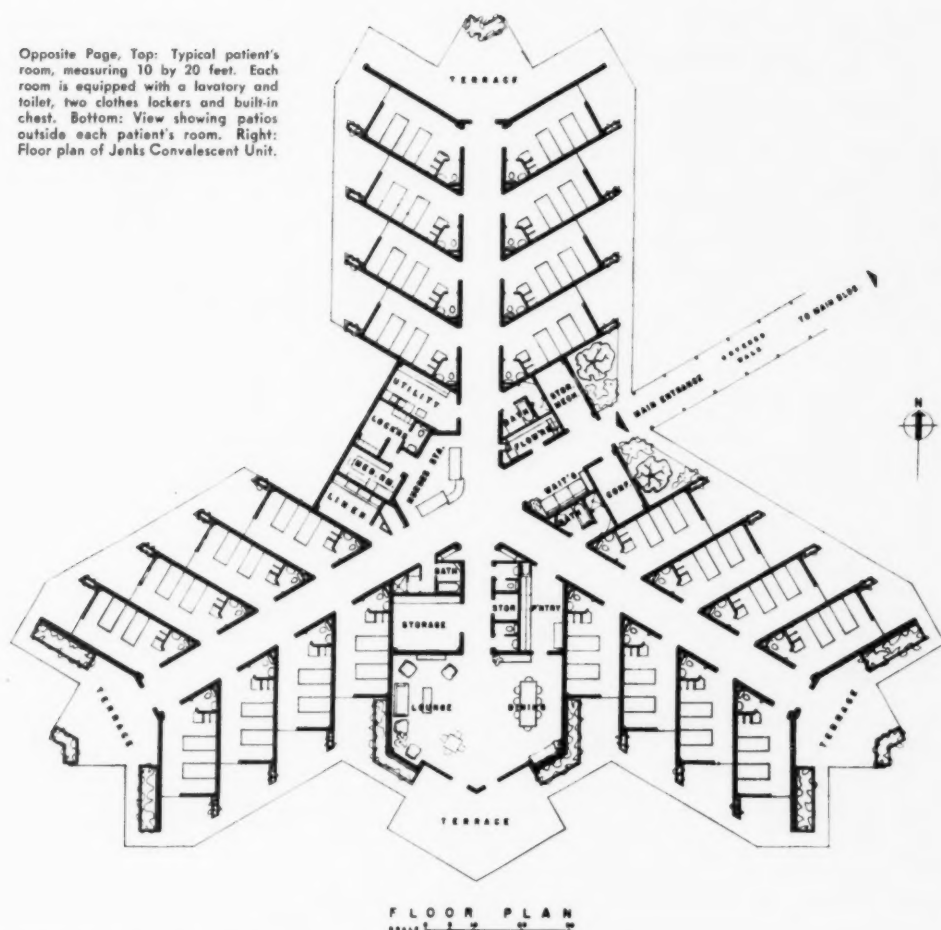
(Text Continued on Page 66)

Opposite Page, Top: View showing patients' patios and lounge terrace. Bottom: Lounge-dining room where meals can be served on trays to patients. This area opens onto a paved terrace.





Opposite Page, Top: Typical patient's room, measuring 10 by 20 feet. Each room is equipped with a lavatory and toilet, two clothes lockers and built-in chest. Bottom: View showing patios outside each patient's room. Right: Floor plan of Jenks Convalescent Unit.



STRUCTURAL DETAILS

Total cost (including architect's fee, furnishings, garden wall, paving and landscaping, but excluding land): \$252,000.

Number of beds: 48.

Cost per bed: \$5250 (all costs).

Number of square feet (not counting 4182 square feet in patios, terraces and covered passage): 11,540.

Cost per square foot: \$14.80 (enclosed area with equivalent

Cost per cubic foot: \$ 1.20 } patio and covered passage cost.

Area per bed: 260 square feet (including patios).

Type of construction: Reinforced concrete (precast, tilt-up).

Roofing: Cordova tile over 3 ply composition roof.

Floors: Ceramic in showers; asphalt elsewhere.

Interior Partitions: In general exposed concrete of tilt-up construction; supplemented with metal lath and plaster partitions and furring to accommodate plumbing pipes.

Doors and windows: Birch slab interior doors, metal frames, steel double hung windows, steel fly screens with copper screening, steel sliding exterior doors.

Drainboards: Laminated plastic.

Heating system: Circulating hot water to wall convectors.

Plumbing: Toilets with bedpan flusher incorporated. All plumbing, heating and electric lines (so far as possible) are in attic, accessible by catwalk.

Ventilation: Exhaust from all inside rooms.

Insulation: Four inches of rock wool in attic space over entire area.

Foundation: Floor slab cast over 6 inch rock and gravel fill, with membrane waterproofing below slab.

Lighting: Fluorescent lights in most corridors and workrooms; individual floor lamps for each patient with adjustable heads for direct and indirect lighting. Night light at mattress height with control at entrance door.

Nurses' call: Complete system (with emergency call) from all patients' beds, patios, toilets, baths, lounge.

Doctors' call: Silent number calls, connected with main building.

Planting boxes: Concrete block with inside waterproofing—open to earth at bottom.

Patients' lockers and dressers: Built-in wood, painted to match room.

Color scheme: Rooms with greater exposure to sunlight have soft green; rooms opposite have soft rose. All patients' rooms have washable plastic wallpaper at head of bed. Sunlight yellow in corridors. Pastel green in service and utility rooms.

Connections to existing buildings: Covered passage with tile roof; high pressure steam from boiler plant to hot water converters for heating and domestic hot water; electrical in metal conduit, domestic water supply from central softening system.

CONVALESCENT UNIT

(Text Continued from Page 62)

immediately adjacent, as well as a large storeroom.

In case of real disaster the convalescent building would provide accommodations for 60 or 70 patients in addition to its regular quota of 48 patients.

The plan of administration of the unit, approved by both the medical staff and trustees, incorporates the following policies:

1. To keep down costs to the patient, only practical nurses will be employed (except for the professional nurse or nurses in charge on each shift) and it is anticipated that the hours of bedside nursing care will not exceed 75 per cent of the hours provided currently in the acute section of the hospital. It is not anticipated that interns or residents will spend much time in the unit.

2. The choice of patients who can be cared for in the unit will be primarily in the hands of the physician subject, of course, to the usual review by the medical staff and in extreme cases by the administrator.

3. Inasmuch as the prime purpose is to relieve pressure on the acute divisions of the hospital, no patients will be admitted directly to the Jenks Building and all must stay at least one day and preferably two days in the acute units. If there are empty

Jenks beds and a patient needs to be admitted in an emergency with no acute bed available, the incoming patient will be kept in the first-aid recovery room until someone else can be transferred to the Jenks Building.

4. The new building is intended as a hospital and not a rest home or boarding home for the infirm; therefore, the length of stay of patients in the Jenks Building will be supervised by the chiefs of the various services as it is in the main building.

5. While it would be desirable to have some single rooms, all rooms will be two-bed whenever so required by crowded conditions in the hospital as a whole.

6. House cases or welfare patients will be eligible to receive care in the new building on a par with full-pay patients.

7. Teaching of practical nurses and other students will be a function of the unit.

The great economy of adding to existing hospitals rather than being forced to create new institutions is dramatically illustrated by the cost of approximately \$5000 per bed in the Jenks Convalescent Building. The hospital was already equipped with power plant, laundry, administrative offices, x-ray department, and so forth, all of which took care of this extra load

without further expansion. It would not, however, be possible to continue this indefinitely as at some point these central facilities would be overloaded.

The tilt-up, precast construction method that was used is a recent development in the building field. All interior partitions, with a few exceptions, all exterior walls, and the roof slabs are cast flat on the ground and then lifted into place, where they are tied together with the columns and piers which are poured in place. The roof slabs are permanently secured by welding together steel sections which are previously embedded in them at strategic locations.

Casting the concrete in a horizontal position eliminates most of the expensive form work required for conventional concrete structures and makes it possible to procure perfectly smooth surfaces, free of form marks and other imperfections inherent in concrete poured in place. The slabs are cast in layers, one on top of the other, at intervals of seven days until all of the casting work is completed. To keep them from sticking together a special coating is sprayed on between slabs, which also acts as a curing agent.

REQUIRES NO FINISH

The surface of the precast slabs is so smooth that no further finish is required, thus eliminating all plastering except for ceilings and for furred spaces to conceal plumbing pipes. All walls of the patient rooms except the short one separating them from the toilets are of concrete, as are the walls of corridors, lounge and utility rooms. When painted, these concrete walls cannot be distinguished from the plastered surfaces and are considerably more durable. A washable plastic wallpaper has been applied to the walls of the patients' rooms at the head of the beds.

Another feature of this unique construction is the sound insulation it provides between rooms. The partition walls extend clear to the bottom of the roof slabs, which they also support, thus providing complete separation between rooms. This complete separation of the attic spaces adds further fire protection in addition to those normal to conventional construction.

A covered passage connects the Jenks Convalescent Unit with main building.



Special Services in the General Hospital

REHABILITATION UNIT

AFTER a major operation, Joe Smith's wound had healed sufficiently for him to go home. His hospitalization, which had been a long one, he had spent chiefly in reading pulp magazines. Beginning his months of convalescence with nothing to do, he ended it the same way, finding finally that for physical reasons he could not return to his former job. Worse still, not even the first step had been taken toward learning a new one.

There was a time when all this, however regrettable it might be, had nothing to do with either the medical profession or the hospital. This is no longer true. Regardless of the discouraging frequency with which cases like that of Joe Smith recur, the responsibility of the hospital and the medical profession is now clear cut.

EXTENDS BEYOND DISCHARGE

One of the distinguishing marks of modern socio-medical thought has been the evolving concept of comprehensive medical care. In simple language, this means that medical responsibility does not end when a pathological process in a certain organ has been arrested. It means also that the interest of the hospital must be projected beyond the date of discharge.

The needs of modern day society make it mandatory that we not only look beyond the illness to the whole patient, but that we consider the whole patient as an individual in relationship to his family, his job, and the community in which he lives.

This evolving concept has made the emergence of the specialty of physical medicine and rehabilitation a historical necessity. With the trend toward

H. WORLEY KENDALL, M.D.

Medical Division
Institute of Physical Medicine
and Rehabilitation
Peoria, Ill.

specialization and the constant increase of knowledge and skills in them, the life-saving potentialities of scientific medicine have made incredible gains in recent years. These very achievements have had social repercussions which we can continue to ignore at our peril.

A glance at the vital statistics shows the shift toward older age groups in the population, bringing with it the problem of rising incidence of disability. Moreover, recent surveys indicate the extent to which physical incapacity has become a factor in our economy. All this is the business of the physician and the hospital.

Writing recently of the new concept of the hospital and its function in the community, Bayne-Jones¹ points out that in order to fulfill its pivotal function in a program of comprehensive medical care, planning beyond the limited scope of the past will be necessary. Except for clinics and ambulatory outpatients, he writes, hospitals in the past have been built to care for sick people in beds. The enlarged scope of the hospital must envision "adequate space for laboratories, for special services, space for physical medicine and rehabilitation."

Since the ideal of comprehensive medical care cannot be realized without physical medicine and rehabilitation, the extent to which these restorative technics are offered as an essential part of the community health program is more or less a measure of the extent to which the ideal has been realized. Here the picture is not as encouraging as it might be, and it appears right now that the best hope for improvement lies with the general hospital.

While the purpose of this paper is to discuss certain practical aspects of organizing and administering a department of physical medicine and rehabilitation in a general hospital, a prior consideration is a clear understanding of the function and scope of this relatively new specialty. Here again, the newness is in the total concept rather than in its elements.

The efficacy of physical agents applied both for diagnosis and treatment has been known for centuries and began to receive emphasis as physical and occupational therapy during and immediately after the first World War. The combined potentialities of light, electricity, heat, cold, massage, therapeutic exercise and other forms of occupational and physical therapy dramatically demonstrated their value in shortening periods of hospitalization, hastening recovery, preventing recurrences, and forestalling or modifying life-long disabilities.

MUST LEARN NEW TRADES

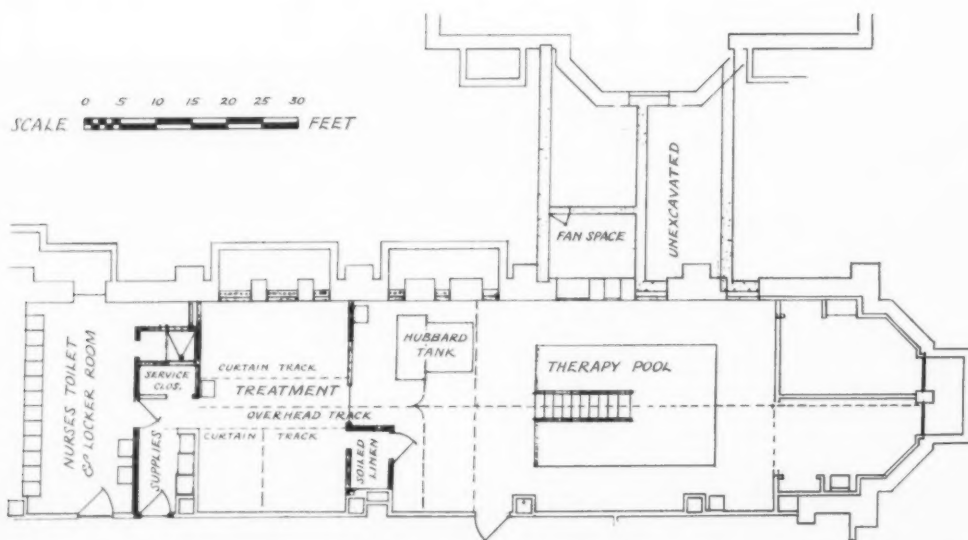
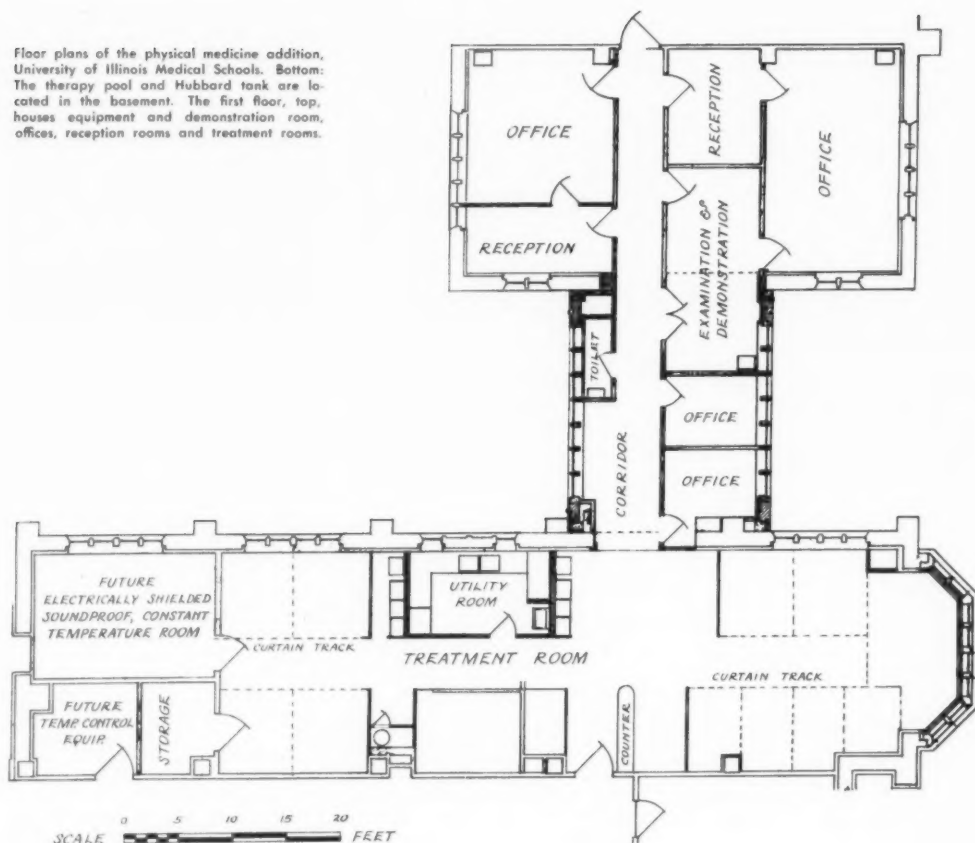
Parallel to these technics was evolving the concept of vocational adjustment, referred to as rehabilitation. Persons recovering from injury or disease, frequently suffering residual handicaps, must often learn new trades or readjust themselves to old ones.

During the second World War the needs of the time inevitably indicated that the more nearly the therapeutic program could be aimed at the ultimate occupational objective, the more efficient and economical the whole process would be. The unmistakable need for a trained medical specialist to stand in a dominant position of responsibility for the whole process of physical medicine and rehabilitation brought a new specialty into being.

Any new specialty inevitably brings with it new problems which range the

At the time this was written, Dr. Kendall was chief of the department of physical medicine and rehabilitation, University of Illinois Research and Educational Hospitals, Chicago.

Floor plans of the physical medicine addition,
University of Illinois Medical Schools. Bottom:
The therapy pool and Hubbard tank are lo-
cated in the basement. The first floor, top,
houses equipment and demonstration room,
offices, reception rooms and treatment rooms.



entire professional spectrum from education to facilities. Since it is our intent to concentrate on the latter, it might be well to point out at once that this is not an entirely uncultivated field. The manual² recently issued by the American Physical Therapy Association, though it limits itself to physical therapy alone, actually constitutes a guide, the outlines of which can encompass other elements of the rehabilitation program for which the physiatrist, *i.e.* a physician who practices physical medicine and rehabilitation, is responsible.

The Baruch Committee on Physical Medicine³ and the Hospital Association of Pennsylvania⁴ have issued valuable suggestions on the practical aspects of organization and facilities for bringing the benefits of physical medicine and rehabilitation to the community.

These and other contributions to the current literature recognize the weakness of generalization; communities not only differ greatly in size but also in the extent and character of available facilities. Immediately after the war, many of us thought in terms of separate rehabilitation centers, and in a few of the larger cities truly splendid institutions of this type have been established.

Disappointing progress in the country as a whole, however, indicates both the need of more flexible thinking and greater stress on existing facilities. An approach of this kind inevitably leads us to a consideration of the community hospital as a civilian rehabilitation center.

The organization of a department of physical medicine and rehabilitation in a community hospital must begin with the community. Intelligent planning requires a thorough knowledge of local needs and resources, and utilization of them should stress integration. If planning is realistic as well as imaginative, many resources and much equipment not located in the hospital itself may be used in various stages of the rehabilitation process, with a net result fully as satisfactory as those achieved with vastly greater outlay in large cities. For example, tools and machinery of the local vocational



school may be scheduled for use under a cooperative plan; or certain exercising facilities in the high school; or graduated work plans with the cooperation of industrial plants.

If actual community need, rather than an arbitrary desire to create a department, is the point of focus, the chance of error will be reduced to a minimum. From that point on, the administrator is ready to estimate his requirements and concentrate on the organization of the department itself.

The total problem can be roughly divided under five headings: (1) personnel, (2) space, (3) equipment, (4) administration, and (5) finance.

Owing to varying conditions previously referred to, any suggestions under each of these headings seldom can be absolutely specific. This applies even to personnel, although in this respect we can speak more definitely than in the others.

As I have observed, the emergence of any new specialty brings with it certain problems, not the least of which is usually the initial shortage of medical personnel adequately trained in it. While one can say unequivocally, therefore, that in the larger institutions, especially teaching hospitals, the departments should be under the direction of a diplomate of the American



Above: A patient works out on the progressive resistance exercise table. Right: Patient receives radiant light to shoulder. Half arc seats for whirlpool baths make treatment of the lower extremities easier and more efficient.



Board of Physical Medicine and Rehabilitation, the present supply of physiatrists is such that in the case of the smaller hospital such recommendation is more easily made than carried out. If a physiatrist cannot be obtained because of this shortage, currently aggravated by military needs, it might be well to give primary consideration to the element of personal interest on the part of the physician responsible for medical direction of the department.

At any rate, it is agreed that the department must be under the direction of a physician. Some smaller hospitals may rely on a general prac-

titioner who has developed a special interest in physical medicine and rehabilitation or they may find it convenient to put the department under the supervision of a physician who has met the qualifications of a specialty board. The selection should be made on the basis of the physician's interest in developing a program commensurate with present-day standards and his willingness to devote adequate time to the program. It would seem, however, to be a sound suggestion to engage, if at all possible, the consultation services of a physiatrist, at least in the organizing stage. If periodic visits for consultation can be

arranged, it will be that much better.

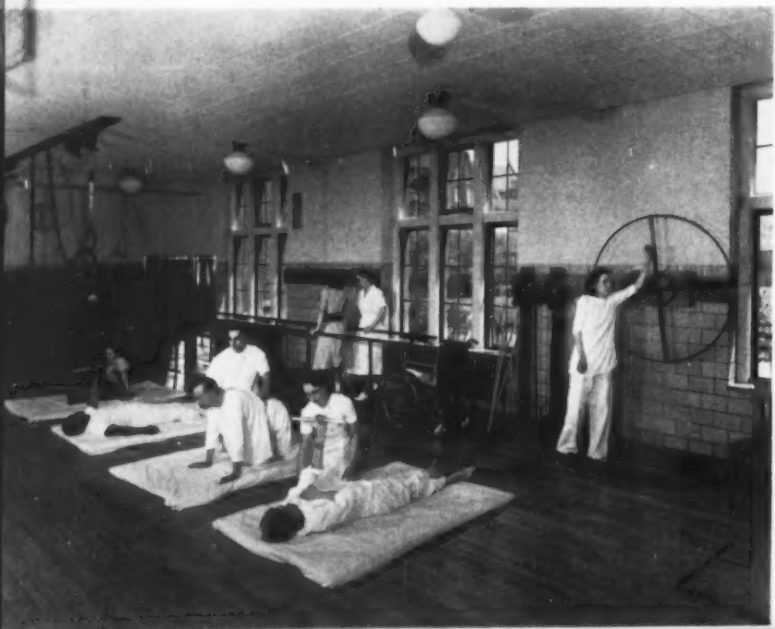
Yet advice concerning medical supervision is comparatively simple when measured by the problem of ancillary personnel. The variables of community size, resources, and the needs of the total rehabilitation process place a heavy burden of individual judgment on the people who are actually going to do the job. The personnel roster may range all the way from a single physical therapist and attendant to numbers of physical therapists and occupational therapists, and all the testing, guidance, teaching and placement personnel ideally available in a comprehensive rehabilitation center.

The American Physical Therapy Association² estimates that one physical therapist is necessary for 15 treatments a day. If this number rises to 20, the addition of one attendant is required. If 71 to 85 treatments a day are to be given, five physical therapists and two attendants are needed. It should be emphasized, however, that there are wide variations in personnel needs and in setting up the personnel budget in a new department it would be wise to seek the services of these specializing in the field.

When one regards the department from the standpoint of the total rehabilitation process, however, modification of these requirements must be considered. If an occupational therapist is added to the staff, it is reasonable to suppose that the retraining for skills carried out according to prescription will relieve the physical therapists of a certain segment of this load.

In taking a broader view of the total rehabilitation process, it may be relevant to note that in agencies both public and private the extent to which use of existing personnel has been integrated generally leaves much to be desired. The smaller hospital that cannot, like Bellevue in New York, for example, staff its rehabilitation center with psychiatrists, psychologists, social workers, instructors for the homebound, and placement specialists should explore the resources of the various state and local agencies, official and

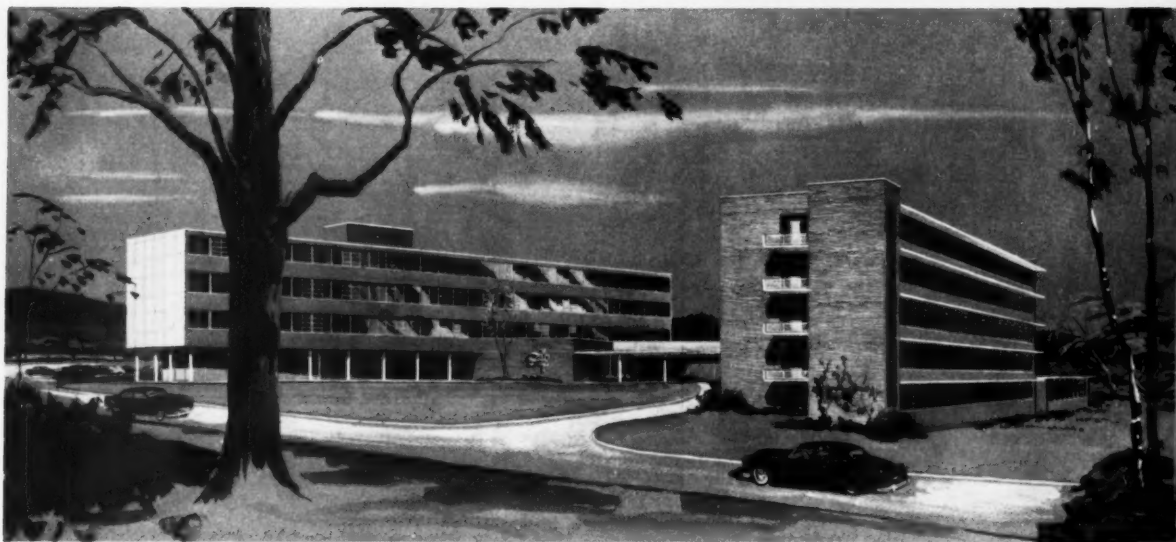
(Continued on Page 118)



Above: In the treatment area high curtain rails permit using all types of equipment in each booth. Below: The rehabilitation gymnasium is equipped with parallel bars, shoulder wheel, exercise mats, mirrors and climbing ropes.

THE MODERN HOSPITAL OF THE YEAR

1951



BRISTOL MEMORIAL HOSPITAL — BRISTOL, TENNESSEE-VIRGINIA
ALFRED L. AYDELOTT & ASSOCIATES, ARCHITECTS

BRISTOL Memorial Hospital at Bristol, Tennessee-Virginia, the hospital that straddles a state line and almost got lost in the jurisdictional shuffle between state hospital planning agencies, was selected as 1951's "Modern Hospital of the Year" by a committee of judges last month. The committee reviewed hospitals published during 1951 in the "Modern Hospital of the Month" series that has been appearing in this magazine.

Bristol Memorial Hospital was designed by Alfred L. Aydelott of A. L. Aydelott and Associates, architects and engineers of Memphis, Tenn. The hospital was published as "Modern Hospital of the Month" in *The MODERN HOSPITAL* for July 1951.

Members of the committee making the selection were Dr. Jack Masur, chief of the Bureau of Medical Services, Public Health Service; Slocum Kingsbury, a member of the architec-

tural firm of Faulkner, Kingsbury and Stenhouse of Washington, D.C., and chairman of the committee on hospitalization and public health of the American Institute of Architects; Marshall Shaffer, chief of the Office of Technical Services, Division of Hospital Facilities, Public Health Service, and Everett W. Jones, vice president of The Modern Hospital Publishing Company.

The Bristol Hospital was planned for 80 beds and includes office facilities for 14 doctors. An alternative plan has also been developed providing an additional floor in both the hospital and doctors' building; the additional hospital floor brings the total bed capacity to 120 and provides space for a staff of 22 physicians. Cost of the project, including the doctors' office facilities, is \$11,800 per bed, making this one of the most economical facilities in the 1951 series.

"My chief reasons for picking the Bristol project were the manner in which the administration and certain services used by both outpatients and inpatients form the connecting link between the doctors' office building and the hospital proper, and the general straightforward way in which the whole scheme is handled," a member of the committee stated in making his selection. "My chief criticism is the lack of toilet facilities in the nursing units. I realize that this runs up the initial cost of a building, but I am sure it adds to nursing difficulties."

Members of the selection committee had difficulty choosing a hospital of the year, it developed in their comments. "You certainly got together an excellent group this year and succeeded in making the choice a very difficult matter," one committee member wrote. "Selecting the hospital of the year this

(Continued on Page 148)

LOUIS S. REED

Chief, Medical Economics Branch
Division of Medical and
Hospital Resources
Public Health Service
Federal Security Agency
Washington, D.C.

HOSPITAL CONSTRUCTION TRENDS

THE purpose of this article is to present the available statistics on the volume and character of hospital construction in this country.

The volume of hospital and related construction in this country is now at an all-time high. In 1951 approximately \$914,000,000 worth of hospital construction was put in place. This compares with \$812,000,000 in 1950. The dollar value of hospital construction put in place during 1951 amounted to more than five times the dollar value of construction in 1946, the first postwar year; it was almost six times the dollar value of construction in 1939, and a little more than four times the dollar volume of construction in 1930 which was the peak year for hospital construction prior to the depression.

A considerable part of the increase in the dollar volume of hospital construction in recent years is simply a reflection of changes in the purchasing power of the dollar. Construction costs increased during the war and have risen steeply in the postwar years. The index of construction costs now stands at 268¹—compared with 100 in 1939, meaning that it now costs approximately \$2,680,000 to construct a hospital which could have been constructed for \$1,000,000 in 1939. However, even after adjustment is made for changes in the purchasing power of the dollar, hospital construction in 1951 stands at an all-time high. In terms of dollars of constant purchasing power, hospital construction in 1951 was more than three times the 1946 volume, more than twice that of 1939, and one and a half times greater than in 1930, the prewar peak year.

¹ American Appraisal Company index for November 1951.

CHART I

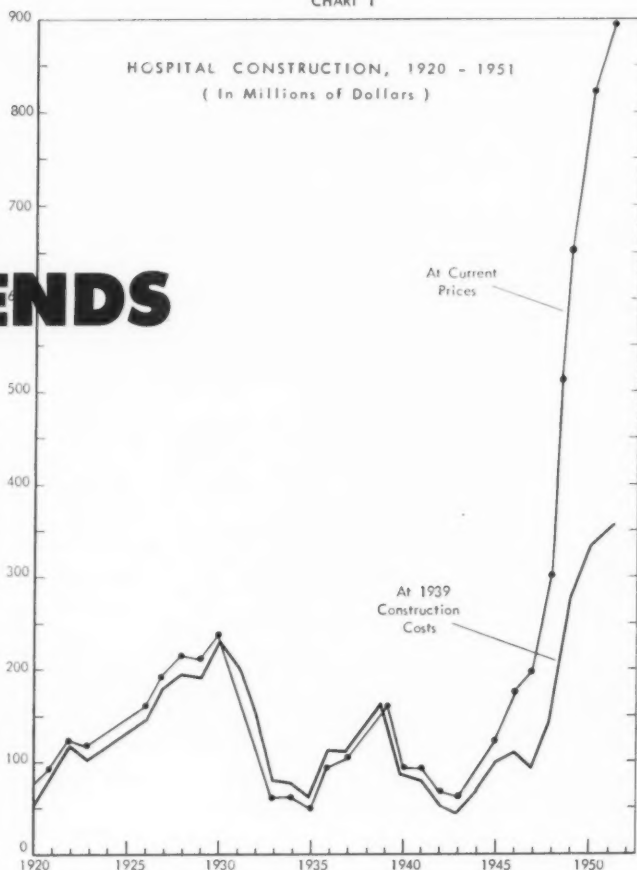


Table 1 and Chart I show the volume of construction in each year from 1920 to 1951, both in terms of current dollars and dollars of 1939 purchasing power.

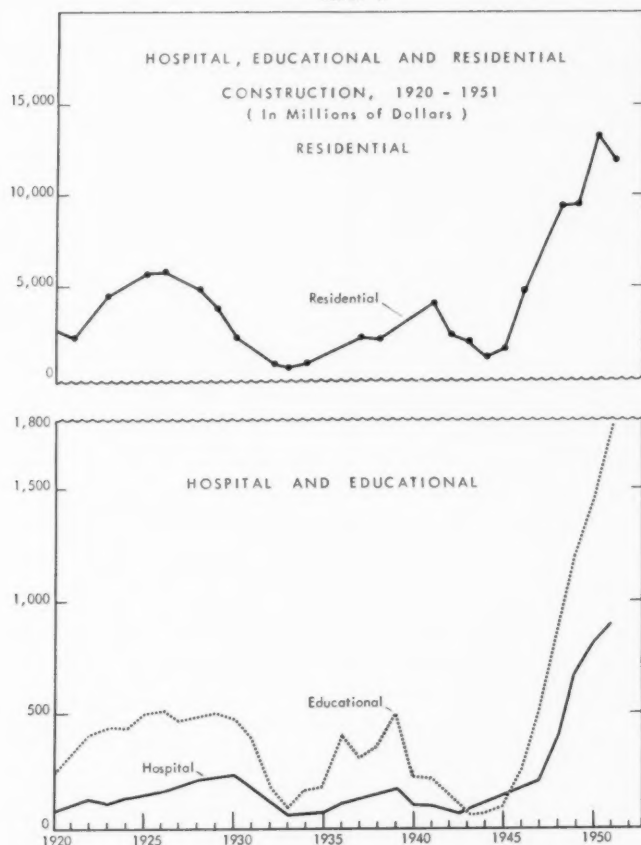
The figures presented here are those compiled cooperatively by the Department of Commerce and the Bureau of Labor Statistics of the Department of Labor. Data on federal construction projects are obtained directly from the federal agencies concerned; data on other public projects and on private projects are based on reports of contracts awarded compiled by the F. W. Dodge Corporation and similar organizations. Supplementary information on federally aided (Hill-Burton) projects is obtained by the Department of Labor from the Public Health Service.

These statistics of hospital construction show the estimated value of con-

struction "put in place" during a given period. The figures are derived from the individual reports on contracts awarded by assuming that a project of a given dollar cost will be completed in a specified number of months—this varies with the size of the project—and that specified percentages of the total dollar cost—again the percentages vary with the size of the project—will be put in place during each month of construction. Construction costs, as reported in these statistics, include architects' fees and the cost of fixed equipment installed under the construction contract, but generally do not include the cost of movable equipment.

The data compiled by the Department of Commerce and Department of Labor as here presented are not confined solely to hospital and related construction (health centers and

CHART II



clinics) but include "institutions" as well. "Institutions" include orphan homes, old people's homes, veterans' homes, poor houses. The Bureau of Labor Statistics found that in 1951 the value of institutional projects represented about 6 per cent of the total for hospital and institutional construction; it estimates that in prior years the proportion of institutional construction has probably ranged from about 5 to 10 per cent of the total. No separate figures are available on hospital construction and the reader should accordingly bear in mind that the figures here presented slightly overstate the volume of hospital construction.

Chart 2 shows the relationship of hospital construction to educational and residential construction. Over the last 30 years as a whole the value of educational construction has been more

than double the value of hospital construction. During the Twenties, educational construction was about three times that of hospital construction. During the early Thirties, educational construction declined much more sharply than hospital construction with the result that in 1933 the volume of construction was about the same in both fields. Then educational construction increased more rapidly and by 1939 was again more than three times the volume of hospital construction. During the war years educational construction again declined more sharply and in 1944 there was actually more hospital than educational construction. At present educational construction is approximately twice the volume of hospital construction. Over the years hospital construction has run at about 4 per cent of total residential construction, and has exhibited ap-

proximately the same ups and downs.

Table 2 shows the amount and relative proportions of public and private hospital construction. Public construction includes hospital projects owned by the federal government and state and local governments. Private construction includes hospitals owned by private organizations, nonprofit or proprietary, and individuals. In 1951 construction of privately owned hospitals represented 46 per cent of the total and construction of publicly owned hospitals, 54 per cent. During the Twenties the relationship was about 52 per cent private, 48 per cent public. During the depression the construction of private hospitals declined almost to the vanishing point; public hospital construction declined, but to a lesser extent, with the result that the volume of construction on public hospitals amounted to three or four times the construction of privately owned hospitals. Again during the war years, the construction of public hospitals considerably exceeded that of private hospitals. Since the end of the war, private construction has increased to a greater degree than has public construction.

Table 3 shows in greater detail the volume of hospital construction under various auspices. Since the war there has been a large amount of construction of hospital facilities by the Veterans Administration. In 1947 some \$30,000,000 worth of hospital construction was put in place on veterans' facilities. This increased to \$97,000,000 in 1948, hit a peak at \$163,000,000 in 1949, and declined to \$134,000,000 in 1950, and to \$120,000,000 in 1951.

The current hospital construction program of the Veterans Administration calls for some 75 projects providing a total of 36,504 beds, and entailing construction costs in excess of \$765,000,000. By the end of the 1950 fiscal year, *i.e.* by June 30, 1950, \$435,000,000 worth of construction had been completed. By July 1951, according to the budget estimates of the Veterans Administration for fiscal year 1952, \$512,000,000 worth of construction was to have been completed, and by July 1952, \$644,000,000 worth will have been completed.²

The volume of construction on Public Health Service and other federal hospitals (exclusive of military hos-

² The Budget of the United States Government for the Fiscal Year Ending June 1952, p. 134.

TABLE 1: VALUE OF HOSPITAL CONSTRUCTION PUT IN PLACE, INDEX OF CONSTRUCTION COSTS, AND VALUE OF CONSTRUCTION AT 1939 CONSTRUCTION COSTS, 1920-1951 (IN MILLIONS OF DOLLARS)¹

Year	Value of Construction	Index of Construction Costs (1939=100)	Value of Construction at 1939 Prices
1920.....	\$ 63	141.1	\$ 45
1921.....	84	107.7	78
1922.....	113	99.7	113
1923.....	112	111.7	110
1924.....	123	110.7	111
1925.....	140	108.2	129
1926.....	151	108.2	140
1927.....	186	108.2	172
1928.....	208	108.2	192
1929.....	205	108.2	189
1930.....	227	99.7	228
1931.....	181	88.7	204
1932.....	117	77.3	151
1933.....	59	74.8	79
1934.....	60	80.3	75
1935.....	48	80.8	59
1936.....	91	84.7	107
1937.....	104	98.7	105
1938.....	132	99.2	133
1939.....	158	100.0	158
1940.....	87	101.9	85
1941.....	88	108.5	81
1942.....	64	120.2	53
1943.....	55	125.4	44
1944.....	84	129.9	65
1945.....	122	135.1	90
1946.....	170	160.6	106
1947.....	195	214.3	91
1948.....	349	244.0	143
1949.....	679	244.4	278
1950.....	812	249.4	326
1951.....	914	264.7	345

¹Source: Bureau of Labor Statistics, U.S. Dept. of Labor, *Expenditures for New Construction, 1915-50*, August 1951. Also, U.S. Dept. of Commerce, *Construction and Building Materials, Statistical Supplement, Construction Volume and Costs, 1915-50*, May 1951. The index of construction costs is that compiled by the American Appraisal Company. See Dept. of Commerce Publication, *Index for 1951*, represents period January through November.

²The figures include institutional construction which constituted about 6 per cent of the total in 1950 and 1951, and probably between 5 and 10 per cent of the total in prior years.

pitals which are not included in these statistics) is relatively small, amounting in 1951 to only \$11,000,000.

Beginning in 1947, federal aid to the states for hospital construction under the Hill-Burton program has played a significant rôle in the hospital construction picture. The first project under this program received final approval in September 1947. The Bureau of Labor Statistics estimates, on the basis of data provided by the Division of Hospital Facilities of the Public Health Service, that in 1948 \$6,000,000 worth of construction was put in place on Hill-Burton projects. This increased to \$124,000,000 in 1949, to \$232,000,000 in 1950, and to \$243,000,000 in 1951. In 1951, construction under the Hill-Burton program amounted to 27 per cent of all hospital construction and to 31 per cent of the total, exclusive of V.A. and other federal hospital construction.

Federal allotments to the states for hospital construction amounted to \$75,000,000 for the fiscal years ending June 30, 1948, 1949, and 1950, to \$85,000,000 in fiscal year 1951 and to \$82,500,000 for fiscal year 1952. At present, the states are using federal funds to pay about 47 per cent of the cost of projects, including equipment costs. At this rate the federal aid program, when it levels out, can be expected to account for about \$176,000,000 worth of construction annually, including equipment costs, or about \$140,000,000 worth of construction, exclusive of equipment not ordinarily installed under the construction contract.

The MODERN HOSPITAL has for many years issued reports, known as Advance Construction Reports, on hospital construction projects. Early in 1951 the Division of Civilian Health Requirements of the Public Health Service, in connection with the allotment of controlled materials to hospital construction projects under the Controlled Materials Plan of the National Production Authority, undertook an analysis and tabulation of these reports.

Nonfederal projects reported on during the period October 1949 through May 1951 were classified by state and an estimate was made for each project of the amount of construction put in place during the year 1950.³ Reports on all projects which could be identified as Hill-Burton projects were eliminated inasmuch as information on these projects was available from other sources.

The tallied projects, of course, did not include all those on which construction was put in place during 1950 inasmuch as projects started prior to October 1949 were not, as a rule, included. However, the construction put in place on the tallied projects did constitute so large a portion of all construction outside the Hill-Burton program, that it could serve as a basis for estimating the distribution of the total nonfederal, non-Hill-Burton volume of construction (\$437,000,000) among the geographic regions of the country.⁴ A similar distribution of the value of construction put in place on Hill-Burton projects during 1950 (\$232,000,000) among the geographic regions was estimated on the basis of the total construction costs of all projects thus far approved under the program.

Table 4 presents the estimates thus obtained of nonfederal hospital construction put in place during 1950 by regions. It will be observed that the total volume of construction in relation to population is greatest in the West North Central states (\$5.82 per capita), followed by the Middle Atlantic states (\$5.74 per capita). The per capita volume of construction was lowest in the East South Central states (\$2.64), and next lowest in the South Atlantic group of states (\$3.76). The volume of construction in the region with the greatest volume is a little more than twice the volume of construction in the region with lowest volume.

Some interesting relationships between the volume of construction under and outside of the Hill-Burton program can be observed. In the West North Central states, with their high per capita volume of construction during 1950, only about one-fourth of the total construction took place under the Hill-Burton program; three-fourths

⁴In general each report gives the construction cost of the project and either the date of contract award or estimated date of completion of construction. In the case of each project it was assumed that the construction would take place over a specified number of months, varying with the construction cost, and that the value of construction put in place would be spread evenly over this period. The value of construction put in place during 1950 was then calculated.

⁵This analysis of the Advance Construction Reports was performed under my direction while I was on detail to the Division of Civilian Health Requirements. Permission to use the data has been accorded by Wesley Gilbertson, chief of the division.

TABLE 2: VALUE OF HOSPITAL CONSTRUCTION PUT IN PLACE, 1920-1951 BY TYPE OF HOSPITAL OWNERSHIP (IN MILLIONS OF DOLLARS)

Period	Total	Private	Public	Per Cent	
				Private	Public
1920-24.....	\$ 495	\$ 247	\$ 248	49.9	50.1
1925-29.....	890	472	418	53.0	47.0
1930-34.....	644	233	411	36.2	63.8
1935-39.....	533	124	409	23.3	76.7
1940-44.....	378	145	233	38.4	61.6
1945-49.....	1,515	560	955	37.0	63.0
1950.....	812	342	470	42.1	57.9
1951.....	914	418	496	45.7	54.3

Source: See Table 1.

TABLE 3: TOTAL HOSPITAL CONSTRUCTION, CONSTRUCTION OF VETERANS ADMINISTRATION FACILITIES, OTHER FEDERAL HOSPITAL CONSTRUCTION AND CONSTRUCTION UNDER THE HILL-BURTON PROGRAM, 1935-1951 (IN MILLIONS OF DOLLARS)

Year	Total	Veterans Administration Facilities	Other Federal Hospital Construction	Total Exclusive of Federal	Hill-Burton Projects	Per Cent Hill-Burton of Total, Exclusive of Federal
1935	\$ 48	\$ 3	1	\$ 45	....	....
1936	91	6	1	85	....	....
1937	104	8	1	96	....	....
1938	132	12	1	120	....	....
1939	158	11	1	147	....	....
1940	87	5	1	82	....	....
1941	88	4	1	84	....	....
1942	64	2	1	62	....	....
1943	55	5	1	50	....	....
1944	84	14	1	70	....	....
1945	122	22	1	100	....	....
1946	170	21	1	149	....	....
1947	195	30	1	165	....	....
1948	349	97	\$ 1	251	\$ 6	.2
1949	679	163	6	510	124	24.3
1950	812	134	9	669	232	34.7
1951	914	120	11	783	243	31.0

¹Not available.

Source: See Table 1. Data on V.A., other Federal and Hill-Burton Construction from Division of Construction Statistics, Bureau of Labor Statistics.

TABLE 4: TOTAL AND PER CAPITA VALUE OF NONFEDERAL HOSPITAL CONSTRUCTION PUT IN PLACE UNDER AND OUTSIDE OF HILL-BURTON PROGRAM, BY REGION, 1950

Region	Value of Nonfederal Hospital Construction	U. S. Population July 1, 1950	Per Capita Value of Constr.	Hill-Burton Construction		Non-Hill-Burton Construction	
				Total	Per Capita	Total	Per Capita
Total U. S.....	\$669,000,000	151,242,000	\$4.42	\$232,000,000	\$1.53	\$437,000,000	\$2.89
New England.....	\$ 40,713,700	9,339,000	\$4.36	\$17,771,200	\$1.90	\$ 22,942,500	\$2.46
Middle Atlantic.....	174,094,000	30,336,000	5.74	34,428,800	1.13	139,665,200	4.60
East North Central.....	124,641,400	30,512,000	4.08	37,328,800	1.22	87,312,600	2.86
West North Central.....	82,339,500	14,149,000	5.82	21,552,800	1.52	60,786,700	4.30
South Atlantic.....	79,759,600	21,235,000	3.76	42,177,600	1.98	37,582,000	1.77
East South Central.....	30,404,700	11,499,000	2.64	25,728,800	2.24	4,675,900	0.41
West South Central.....	54,912,200	14,552,000	3.77	33,848,800	2.33	21,063,400	1.45
Mountain.....	24,247,400	5,121,000	4.73	7,029,600	1.37	17,217,800	3.36
Pacific.....	57,887,500	14,499,000	3.99	12,133,600	0.84	45,753,900	3.16

TABLE 5: DISTRIBUTION OF NONFEDERAL HOSPITAL CONSTRUCTION DURING 1950 BY TYPE OF FACILITY

(Value of Construction Put in Place)

Type of Facility	Total		Hill-Burton		Non-Hill-Burton	
	Amount	Per Cent	Amount	Per Cent	Amount	Per Cent
General.....	\$485,242,000	72.5	\$190,704,000	82.2	\$294,538,000	67.4
Mental.....	130,313,000	19.5	12,760,000	5.5	117,553,000	26.9
T. B.....	29,204,000	4.3	9,976,000	4.3	19,228,000	4.4
Chronic.....	8,762,000	1.3	7,888,000	3.4	874,000	0.2
Health Centers.....	13,294,000	2.0	10,672,000	4.6	2,622,000	0.6
Clinics.....	1,748,000	0.3	.....	.....	1,748,000	0.4
Nursing Homes.....	437,000	0.1	.....	.....	437,000	0.1
Total.....	\$669,000,000	100.0	\$232,000,000	100.0	\$437,000,000	100.0
Type of Project						
New.....	\$269,550,000	40.3	\$126,210,000	54.4	\$143,340,000	32.8
Additions.....	399,450,000	59.7	105,790,000	45.6	293,660,000	67.2
Total.....	\$669,000,000	100.0	\$232,000,000	100.0	\$437,000,000	100.0

took place outside of the program. In the Middle Atlantic states, less than 20 per cent of construction took place under the program. On the other hand, in the East South Central states more than 80 per cent of the entire volume of construction took place under the Hill-Burton program. In the South Atlantic states a little more than half of the total construction was under Hill-Burton; in the West South Central states, a little more than 60 per cent.

It is quite clear from these figures that the Hill-Burton program is playing an important rôle in increasing the volume of hospital construction in the poorer states and in distributing health facilities more evenly throughout the country.

Table 5, derived from the same

sources as Table 4, shows the distribution of hospital construction in 1950 according to type of facility. Of the total amount of nonfederal hospital construction put in place, general hospitals represented 72.5 per cent, mental hospitals 19.5 per cent, and tuberculosis hospitals 4.3 per cent, with the remainder scattered among health centers, chronic disease hospitals, clinics and nursing homes. General hospitals make up 82.2 per cent of the construction under the Hill-Burton program, only 67.4 per cent of the non-Hill-Burton construction. Very little construction on mental hospitals took place under the Hill-Burton program—less than 6 per cent; by contrast almost 27 per cent of construction outside the Hill-Burton program consisted of mental hospitals. Almost all of

the construction on health centers and chronic disease hospitals took place with federal aid.

Table 5 also presents information as to whether the projects are for the construction of new hospitals or additions to existing ones. Under the Hill-Burton program 54 per cent of the volume of construction represents new hospitals. Outside of the Hill-Burton program, the situation is reversed: less than one-third of the total volume of construction is for the building of new hospitals; more than two-thirds represents additions to existing hospitals. This showing is in line with the fact that much of the construction under the federal aid program is in small towns and rural areas which have not previously had the benefit of hospital facilities.



an architect brings a
fresh point of view to the
problem of the hospital expert

THE QUESTION IS NEVER THE SAME

ROGER ALLEN

Roger Allen and Associates
Grand Rapids, Mich.

AN EXPERT has been defined as a fellow from out of town. My own revised version, sometimes known to scientists as "Allen's Law," reads, "An expert is a fellow from out of town who won't stay there."

For some reason I am continually being insulted by experts. I do not know why this is, as I am kind to the folks, pay my taxes—and incidentally I deplore all this talk about dishonest tax collectors—it is a well known fact that this country has the best tax collectors that money can buy—and I am quoted on the loyalty test at 7 to 5 in the morning line. What more could you ask?

Nevertheless, experts are always making some derogatory remark to me. For instance, I am sitting in on a seminar in Indianapolis conducted by the American Institute of Architects and an expert on acoustics is talking. He is referring to the difference in acoustic properties between an empty room and one filled with people. It seems people absorb sound. Strictly speaking, the people do not absorb the sound; it's their clothes. "Acoustically speaking," the expert went on, "each of you in the audience is the equivalent of 4 square feet of open window." This gratuitous insult naturally incensed me. I did not look like 4 square feet of open window; I merely happened to be yawning.

And what happened the other day? I am about to make preliminary drawings for a mental hospital in Michigan and in a conscientious effort to catch up on the latest info from the more learned brothers I subscribe to a quarterly magazine so intellectual that it costs \$7 a year and no pictures.

What does it say in a lead article in the first issue I get? It says two psychiatrists have proved to their own satisfaction, but not to mine, that "hearing defects are from two to 16 times as frequent among the mentally deficient as among the population as a whole."

On reading this, I turned off my earphone and observed two minutes of sullen silence.

Actually, my topic is the hospital expert, the consultant, the fellow from out of town, from the standpoint of the architect who is a general practitioner. This is a subject on which I have very decided views. I refer to them as "decided" because every time I have aired them a certain number of people—frequently, alas, potential clients—have decided that I had better go upstairs and lie down with a damp cloth on my forehead.

The theory that the best hospitals are designed by architects who design nothing but hospitals is not susceptible of proof. I feel that if Frank Lloyd Wright, Alden Dow, Richard Neutra or half a dozen architects who, as far as I know, have never designed a hospital, should suddenly haul off and do so the effect would be the production of a hospital that would not only function beautifully but be an agreeable esthetic experience to behold. You know why I think so? For one reason, because one of the best recent hospitals that I have seen, up at Salem, Ore., was designed by Pietro Belluschi, and I understand it was the first time Mr.

Belluschi had ever tangled with the problem of the hospital.

Frankly, architects can make mistakes enough of their own without being abetted by consultants. Let us examine a few of these mistakes, without identifying the authors, which would be embarrassing, especially if the author turned out to be me. Let us take the theory that recently had a wide vogue—the walls of a hospital should be mostly glass. Privately I consider this a result of the American passion for view windows; in fact, I once announced to an audience that the history of domestic architecture in America could be summed up in the phrase, "From few windows to view windows." Nobody laughed.

I daresay there is some therapeutic value to sunlight; but I have never forgotten the answer a nurse gave me when I was inspecting a hospital in which the entire outside wall of the patient's room was glass. I noticed that the draperies had been drawn so that only about one-third of the glass was exposed. "Do you always keep the draperies drawn?" I asked.

"Usually," she admitted.

"Why?" I inquired.

"Let me ask you a question," she replied. "When you have a headache do you take a couple of aspirin and lie down in a room with the sunlight blazing in, or do you pick out a room you can darken?" I admitted I holed up in a dark room.

"So does everybody else," said the nurse, who was obviously a deep thinker. "If you think people come into a hospital for the purpose of hanging out the window and admiring the view, you are wrong."

The mechanical equipment of hospitals, to jump around a little, has always seemed to me to be a subject of morbid interest. I do not know how many hospitals there are around the country where patients learn to their horror that they cannot use an ordinary radio, which uses alternating current, because somebody has thoughtfully provided the institution with direct current, but there are quite a few of them. This is a serious matter, for when you come between a free American and his radio or TV programs you are treading on dark and bloody ground.

By what I can only consider a stroke of blinding genius, it has now occurred to one and all that oxygen can be piped to each and every room, thus eliminating the trundling through the hall of large cylinders. This is a pity in a way, because this healthful exercise benefited the orderlies, many of whom developed large muscles and went on to win fame as basketball players of such eminence that they got indicted for shaving points instead of patients.

Let us return to architects, and the subject of the balcony. It is a well known fact that balconies can be integrated into the design of an elevation so that they break up the flat surfaces and make a striking light pattern. It does not seem to be quite as well known a fact that patients virtually never sit on these balconies. I have checked this repeatedly, and I would make a small bet that there are balconies on hospitals all over this fair land on which no patient sets foot from one year's end to another. This may be due to the fact that he distrusts balconies or to his suspicion that sitting on balconies is not included in his Blue Cross coverage and is hence an extra. Balconies cost a great deal of money and it would be better to let the light pattern worry over its own problems.

I once listened to a consultant who knew all about the pharmacy department of a hospital explain how much floor space to allow for this facility in a 250 bed hospital. I checked afterwards and found that the floor space figure he gave was greater than that occupied by the pharmacies of the three leading prescription pharmacies of Grand Rapids. Not ordinary drug stores, you understand; three pharmacies doing prescription work almost exclusively. I am not prepared to admit that a 250 bed hospital can use

up more pharmacy services than a town of 175,000 population, unless one of the pharmacists has set himself up in the distilling business and is retailing quarts of Old Recent to all comers.

One of the things that annoys me about consultants, or I should say some consultants, is their disinclination to hear me expound my views on the multiple use of rooms, whether in hospitals or other types of buildings. Hospitals now cost so much money per bed that they have in many localities priced themselves right out of the market. One reason is that if somebody decided tomorrow that every modern hospital required a room for deep therapy for ingrown toenails, then inside a few months it would be axiomatic that a separate room must be provided for this dread scourge of mankind; to suggest doubling up and using the room devoted to deep therapy for hangnails would be as much as a man's life is worth. Why is this?

Educators are learning this lesson. They learned it the hard way, but they learned it. In more and more school buildings you will find multipurpose rooms, as such, and more rooms that can if need arises be used for more than one purpose. The problem is tougher in hospitals because there are fewer opportunities for multiple use. But there are some.

By some strange mischance I have arrived at a point opposite where I



came in. I am no longer so sure architects are brighter than consultants. I will close hurriedly; this is defeatism.

Consultants can render valuable service in the designing of hospitals and I know half a dozen of them who improve any structure they assist on. But a consultant, an expert, a fellow from out of town, is always in imminent danger of learning all there is to be learned about his subject. When this happens he's sunk. A man who knows all there is to be known about a subject is a dead duck. Better he should stay home and work doublecrosses. His ideas, like concrete joists, are prefabricated. He knows what the answer is before anyone tells him what the question is. He thinks it's the same question as last time.

This leads to Allen's Law No. 2, which reads, "The question is never the same question as last time." There are no "average" hospitals, no "average" bottling plants, no "average" pretzel-bending warehouses. There are no average anything. There are no average people. Every problem is different. If it weren't, you could have architecture as far as I am concerned. The thing that has kept me continuously excited about my profession for nearly 40 years (I am an old, old man, particularly of a Monday) is that the problem is always changing, always different. Unless you come to it fresh, as to a new problem, and one that nobody else ever solved completely and satisfactorily, your buildings are not going to lift men's spirits. They're merely going to lower their bank accounts.

Building and Equipping New Hospitals

under the Controlled Materials Plan

WESLEY E. GILBERTSON

Sanitary Engineer Director
Chief

Division of Civilian Health Requirements
Office of the Surgeon General
Public Health Service
Federal Security Agency

WHAT is the effect of the Controlled Materials Plan on hospitals? Will new hospital construction proceed in 1952 at the same high level? How well can we equip our new hospitals upon completion?

In late 1950, the Federal Security Agency was designated a claimant agency under the Defense Production Act. Immediately, the agency's responsibility in the field of health and sanitation was delegated to the Public Health Service and the Division of Civilian Health Requirements was created to conduct the new claimant program: Estimating, presenting and justifying the nation's health and medical requirements for the civilian population—and allocating controlled materials to construction projects.

WHO CONTROLS PRODUCTION

Control of production for defense is divided between the planning organization of the Defense Production Administration—D.P.A.—and its sister operating agency, the National Production Authority—N.P.A. The Controlled Materials Plan—C.M.P.—which became effective July 7, 1951, is best described as balancing supply and demand within the known resources of steel, copper and aluminum—the three basic metals chosen for control. Twenty agencies in addition to the Federal Security Agency, as well as 35 industry divisions in N.P.A., represent various segments of the national economy as claimant agencies.

The Public Health Service claimant program is twofold:

First of all, the Division of Civilian Health Requirements grants permission to construct civilian hospitals and health facilities; at the same time, it issues individual allotments of controlled materials. Second, but by no

means a subordinate activity, the program embodies a continuous analysis of the domestic distribution of health and medical supplies and equipment for civilian use. Other activities related to these two functions include representation on N.P.A. industry advisory committees and rendering assistance to industries where expansion of production facilities is vitally needed. The Public Health Service program does not, however, include the constructing or equipping of military or Veterans Administration hospitals or water supply or sewage disposal in the field of sanitation; these areas are represented by other claimant groups.

One of the initial steps taken by the Public Health Service in the pre-C.M.P. period was to estimate the future consumption of more than 1100 products which are essential to health and medical care. Estimates were also prepared for the construction materials, particularly metals, required for the building of hospitals and other health facilities coming under the jurisdiction of the Public Health Service. To the control authorities, the service urged expanding productive capacity where study revealed that critical shortages of health and medical supplies and equip-

ment might be encountered with the onset of defense mobilization.

Under C.M.P., the Public Health Service receives quarterly allocations of controlled materials from D.P.A. for distribution to health facilities already under construction—the majority of which are hospitals—and to provide for new construction "starts," as well. From the C.M.P. "bank" of controlled materials, metals are allotted to eligible projects by issuing authorizations to purchase approved amounts.

Issuance of allotments to each project follows careful screening for essentiality.

Today, all uses of critical materials demand careful examination.

THESE ARE THE QUESTIONS

Why is construction of the hospital required—at this time? Can it be deferred for three or six months? Have financing arrangements been completed? How will the facility be staffed? Are enough doctors available? Nurses? What is the relationship to the defense effort? Will it serve an immediate, or a potential, community need? Will it alleviate overcrowding? Will it replace or add to an existing facility?

The answers to these and similar questions are reviewed by the state hospital planning agencies and the Public Health Service regional and central offices in considering C.M.P. applications. New hospitals less urgently needed may have to be postponed for one quarter, or more. All applications are graded according to degree of essentiality. Projects are given first consideration if they increase, or maintain, beds in "critical" defense areas where the need is urgent. New facilities contemplated for communities not now served by hospitals



are assigned second place. Then follow the areas with descending degrees of hospital bed shortages.

To consider the impact of C.M.P. on programs for improving our standards of medical care and the alleviation of recognized bed shortages, certain factors can be analyzed at this time. Let us examine four of them:

1. The current rate of new construction of hospitals permitted under the Controlled Materials Plan may be compared with the recent past.

2. The metals quotas granted under C.M.P. may be compared with the known and estimated construction materials requirements.

3. An analysis may be made of the current rate of hospital construction and its bearing on unsatisfied bed needs.

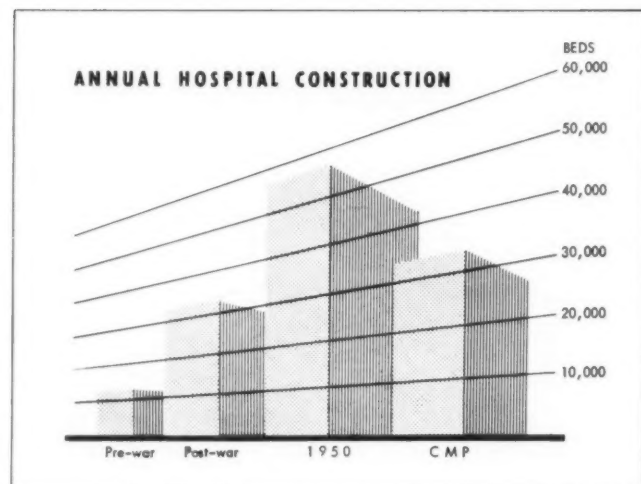
4. Future trends may be forecast within the limitations of the actual operating experience of the first four calendar quarters under C.M.P.

Accurate figures on the completion rate of new hospital beds for the decade beginning in 1930 are not available. Our best estimates show that the yearly construction average between 1930 and 1939 provided an additional capacity of approximately 11,700 beds. Building dropped in the depression years—especially hospital construction. Early war years saw some emergency building of hospitals but not in sufficient volume to dent the long-accumulated bed deficit.

P.L. 725 FURNISHED STIMULUS

When materials became available after World War II, new hospitals were started and the long overdue modernization of existing plants began. Obsolete equipment was replaced. Existing facilities were expanded for increased services. Additional buildings were erected in response to the acute needs of growing communities. The passage of the Hill-Burton Act (Public Law 725, 79th Congress, 2d session), which provided federal aid for hospital construction on a matching-fund basis, was a stimulant. With the impetus provided by this act in the years between 1947 and 1950 construction of hospital beds jumped to an average annual increase of 32,800 beds.

By January 1951, the total acceptable hospital bed capacity in the United States and its territories exceeded a million beds. Approximately 57,000 beds were added to the acceptable category in 1950 with an actual gain, however, of 45,000, because of normal



The C.M.P. or 1951 figure in the above chart does not include beds converted from nonacceptable to acceptable categories.

attrition which took a toll of an estimated 12,000 beds. The nation's bed deficiency was still approximately 875,000, and only 54 per cent of the needs were met.

More than 2200 construction project proposals have been processed by the Public Health Service since the beginning of C.M.P. Of this number, approximately 55 per cent represents hospital and health facility construction under way as of July 7, 1951, and 45 per cent represents new "starts."

Because full C.M.P. has been operating only since last July, our statistical data cover less than a year's actual experience. Controlled materials must be allocated well in advance of the calendar quarters in order to achieve co-ordination between the hospital contractor and the mills; therefore applications must be filed at least four months before each quarter. Current health facility construction can be analyzed, at this stage, only in terms of metals requested, metals received, and types of projects processed since the beginning of C.M.P.—a "paper" period of four calendar quarters. Table 1 shows our record of stated requirements, allocations and the percentages of allocations to requirements for each quarter.

To understand the situation better, the following summary of project actions may be helpful:

Of the 381 "starts" submitted for the fourth quarter of 1951, 77 per cent were approved for that quarter. In the

first quarter of 1952, most of the deferred projects held over from the previous quarter were approved and, in addition, with the materials available, 57 per cent of the 276 first quarter proposed "starts" could be authorized. An improved materials allocation for the second quarter 1952 has permitted approval of all deferred projects remaining from the fourth and first quarters and a majority of the proposed second quarter "starts" as well. Briefly, this means that the earlier trend of deferrals has been checked and reversed.

PROJECTS RECEIVING PERMITS

One method of analysis is expressed in Table 2 which shows the number of hospital projects receiving permits and the number of beds they will provide. New hospitals and expansions are included in the analysis but excluded are projects for rewiring, boiler repair, re-roofing, or any similar jobs not adding to the bed capacity of a facility. The figures shown for the first half of 1952 are by their nature estimates, and, as such, represent proposed hospital projects approved on the basis of the controlled materials available for allotment as of the end of January 1952.

We estimate the expected total of additional hospital beds to be provided by new construction projects starting during the 12 month C.M.P. period beginning July 1951 and ending June 1952 as approximately 36,000. These 36,000 new beds represent only part of the expansion in hospital service

Table 1—P.H.S. Requirements and C.M.P. Allocations for Health Facility Construction by Calendar Quarter

	Carbon and Stainless Steel (tons)	Copper Wire and Brass Mill Products (thousands of lbs.)	Aluminum (thousands of lbs.)
Third quarter 1951:			
Requested.....	102,852	7,256	1,059
Received.....	75,475	4,514	550
Per cent of requests received..	73	62	52
Fourth quarter 1951:			
Requested.....	101,206	4,375	1,049
Received.....	81,529	2,640	500
Per cent of requests received..	81	60	48
First quarter 1952:			
Requested.....	99,305	3,699	619
Received.....	71,285	2,733	400
Per cent of requests received..	72	74	65
Second quarter 1952:			
Requested.....	90,665	4,650	665
Received.....	75,300	2,723	388
Per cent of requests received..	83	59	58

Table 2—Construction of Hospital Beds Authorized Under the Controlled Materials Plan

Period of Authorization Issuance	Number of New Projects Approved	Estimated Additional Beds
1951 (July-Aug.-Sept.).....	120	9,800
1951 (Oct.-Nov.-Dec.).....	160	10,300
1952 (Jan.-Feb.-Mar.).....	100	7,100
1952 (Apr.-May-June).....	120	9,000

authorized under C.M.P. Approximately half of the applications received represent projects which relate to improvement of service and safety. Obviously any existing beds will be certified as acceptable by state agencies after construction is completed.

THERE WILL BE DELAYS

These figures indicate that today's rate of hospital construction is not meeting today's needs. It is evident that although hospital construction is proceeding quite well, the present rate of programming will cause some delays in progressing toward the goal. Nevertheless, it should be stressed that without C.M.P. contractors would be competing for materials in a scarce market, opening the door to price abuses and other discriminatory practices.

In N.P.A. there are two industry divisions whose programs are allied to the health area. These are the Consumers Durable Goods Division and the Scientific and Technical Equipment Division. Both share responsibility for the allocations of metals to manufacturers of hospital supplies and equipment.

The Scientific and Technical Equipment Division allocates controlled ma-

terials for the manufacture of surgical and medical furniture, equipment and accessories, optical instruments and ophthalmic goods, laboratory, dental, surgical, medical and scientific instruments, and surgical and orthopedic appliances and supplies. In this division's essentiality classification there are three preference groups. Our interest is in the second (just below direct armaments and defense requirements) where the medical and surgical types of equipment required for civilian health use have been placed.

According to its director, Howard A. Pringle, the Scientific and Technical Equipment Division "is exerting every effort to provide sufficient medical equipment and instruments for both military and essential civilian needs. Some substitution of less critical for more critical materials may be necessary whenever the functional qualities of the product will not be impaired by such substitution. There is every indication that there will be adequate supplies in all essential categories for all needs in this field."

The Consumers Durable Goods Division classifies as "preferred products" all items possessing military, public health, medical or civil defense application. "We consider health and med-

ical supplies as 'preferred products' and give them top priority along with many military items," the division's director, Harry J. Holbrook, has stated, adding, "Hospital kitchen equipment, for example, is vitally important to the successful operation of our medical care institutions. We will do our best to see that sufficient materials are channeled into these essential products to care for real needs."

The increase in civilian demand and ascending military and civil defense purchases are responsible for the enlarged demand for medical supplies. Population growth, improved living standards, and the general economic status have produced a popular demand for more, and better, medical care. This has, in recent years, contributed to the increased civilian consumption of medical supplies.

As for the military, it is believed that its procurement program will absorb \$425,000,000 of medical supplies before July. Balance this expenditure with the fiscal year preceding Korea, ending June 1950, when \$35,000,000 was the extent of the same program. Appropriations for civil defense purchasing of medical supplies were made available in 1951; in 1952, it is expected that civil defense buying will range between \$75,000,000 and \$85,000,000 of combined federal and state funds for emergency stockpiling.

SCRAP DRIVES PROMOTED

In a sense, part of the control problem cannot be readily solved. The controlled materials available are not sufficient. Scrap drives to recover usable metals are being promoted. Programs for expanding metals production are well under way. It takes steel to produce steel. We know that a significant portion of the current supply of controlled materials must be devoted to increasing industry's productive capacity.

The first months of controlling materials and production have been a period of transition. We may expect to see in 1952 a lengthening of the transitional period, and a sharpening and tightening of control measures. At the same time, we may expect that, with no change in the international atmosphere, construction of hospitals and the manufacture of medical supplies and equipment for civilian consumption will continue because they are recognized as indispensable health programs—but the level may be lower than we want to see.

Finance Commission Moves Ahead

as critics wave arms about "bias"

CHICAGO.—Circling to gain altitude for its two-year flight toward the answer to hospital financial problems, the Commission on Financing Hospital Care last month was studying weather charts showing dark clouds on the horizon to the right. After a careful look at the clouds, however, navigators concluded that they appeared more threatening than they actually were and would not cause a change in the commission's flight plan.

Following a series of regional conferences planned to disclose which hospital financing problems were most urgent, the commission staff returned to its Chicago headquarters, where the paint was still fresh, to find that it was under fire for supposed "socialist bias"—largely because of the presence on the commission staff of associate director Harry Becker, formerly director of the social security department of the United Automobile Workers, C.I.O.

CHAMPIONED BLUE CROSS

Outspoken critics of the commission for this and other presumably suspicious connections and dangerous designs were the Association of American Physicians and Surgeons, an organization which once proposed a sit-down strike of doctors in event a national health insurance program should be adopted, and Marjorie Shearon, a former employee of the Social Security Agency, whose epic quarrel with F.S.A. economist Isadore Falk made bureaucratic history in the 1930's and who has devoted herself since that time to the composition of *Challenge to Socialism*, a periodical bulletin whose political and social views make the *Chicago Tribune* and Westbrook Pegler look like wide-eyed radicals.

In addition to the catcalls of A.A.P.S. and Shearon, some genuine misgivings have been expressed by certain medical groups and individuals whose disquiet derives not only from the fact that Becker and Graham Davis, commission

ROBERT M. CUNNINGHAM Jr.

director, are slightly to the left of the McKinley-Coolidge axis which some doctors regard as the only safe orientation, but also from the fact that they fear the commission's existence may be symptomatic of a growing trend toward organization of all medical services in and around hospitals and thus speed dreaded "hospital domination" of medical practice.

If there is some basis for such misgivings as these, there is not much sense, or truth, in the A.A.P.S. allegation that Becker is "one of the country's most militant advocates of government control of medical and hospital care," and that he has "spent many years propagandizing and working for socialized medicine" and is a "bitterly biased devotee of federalized medical and hospital care." The fact is that Becker is a former employee of the U. S. Children's Bureau, whose director at the time, Dr. Martha Eliot, is one of the government's few outspoken critics of compulsory health insurance. As social security director of U.A.W.-C.I.O. for the last four years, Becker has been a champion of Blue Cross-Blue Shield coverage for union members; he fought and bled for the plan under which 3,000,000 auto workers and dependents are now protected and under which, in 1951 alone, they received \$125,000,000 in benefits—\$50,000,000 of it paid to hospitals by Blue Cross in their behalf. Becker's forthright demands on voluntary insurance plans ("You give us what we want or we'll get it from the government!") have frequently been mistaken for support of socialized medicine but actually contemplate a system that is different from government medicine in the same way that the Standard Oil Company differs from the army: The design is similar but the auspices are poles apart. As it has turned out,

the U.A.W. and Becker were smart to take Blue Cross-Blue Shield instead of a government plan: Auto workers get more benefits for less money now than they would get under any plan yet proposed by the government.

CLAIM NOT JUSTIFIED

In a recent issue of *Challenge to Socialism*, Marjorie Shearon traced Becker's career through the Children's Bureau and U.A.W. and took a dim view of his activities as president of the Group Health Association of Washington, D.C., the prepayment medical care plan for federal employees that tangled with the American Medical Association in 1937, his work with the steering committee of the National Health Assembly of 1948, and his rôle in the establishment of the Cooperative Health Federation of America, an organization of consumer cooperatives offering medical care programs. While these and other interests of Becker's over the last 15 years certainly indicate a willingness to revise traditional methods in the distribution of medical and hospital care that one would not find in, say, a trustee of the A.M.A., they scarcely justify the Shearon claim that he is "one of the strongest lobbyists for the nationalization of medicine," and, in fact, Becker and his associates on the commission staff deny that he has personally favored or endorsed compulsory health insurance since he left government service in 1948. In government as in business, it should be noted, a certain amount of enthusiasm for the boss's pet schemes is consistent with continued gainful employment.

Like political reactionaries who refuse to acknowledge that there is a difference between social reform of any kind and communism, critics like Shearon fail to distinguish between all-out government medicine and the kind of government participation in financing medical care that Becker and others have sometimes advocated. "Govern-



BECKER

SHEARON

DAVIS

ment will by necessity have to fill the gap that exists in our present system of financing personal health services," Becker said in an address to the Ohio Hospital Association at Columbus two years ago. "Government will have to assist in coordination of methods of prepayment," he continued. "Government must assist in financing the facilities needed to supply hospital beds to all communities. This governmental participation must not blind us to the great importance of individual responsibility in this evolving system. . . . Traditionally our citizens first try the individual and the group approach to solve their problems. But when such efforts have failed, they have used the instrument of government. If the medical profession fails to work with the people in the solution of their mutual problems, the people—who, after all, are the government—will take the next step."

MISUNDERSTAND A.H.A. ROLE

When they aren't brooding about the staff, A.A.P.S. and Miss Shearon are worrying about the relationship between the commission and the American Hospital Association and, incidentally, exhibiting considerable misunderstanding as to just what this relationship is. "The commission is a project of the A.H.A. and actually under its direct control," an A.A.P.S. newsletter asserted recently. This is an understandable error, perhaps, since the commission was in fact conceived by the A.H.A. three years ago. But the six-member planning committee which drafted its outline for study included Dr. Morris Fishbein, then editor of the *A.M.A. Journal*, and Dr. Louis H. Bauer, now A.M.A. president-elect, and the commission as it has evolved is not beholden to the A.H.A. or any other organization and can proceed inde-

pendently along whatever lines, and to whatever conclusions, its members may decree.

There are 12 doctors of medicine among the commission's 32 members. Most of these are connected with medical education, hospital administration or public health—all fields which the average doctor in private practice contemplates with raised eyebrows. One commission member, Dr. Leonard W. Larson of Bismarck, N.D., a pathologist, is a trustee of the American Medical Association, but the field of private practice is not represented directly on the commission at all. The commission is planning, however, to include such representation on a technical advisory committee now being organized.

Stated objectives of the commission study include analysis of the effect of medical practice on hospital costs, determination of the need and demand for hospital services, and investigation of methods for facilitating the most effective utilization of hospital resources—all areas necessarily impinging, if not actually intruding, on the private practice of medicine, and all therefore certain to send a few sensitive doctors ducking and weaving into the middle of the ring.

While there is probably no way to avoid a certain amount of conflict between the commission's findings and eventual recommendations, on the one hand, and independent, untrammelled private practice on the other, the important thing will be for all hands to understand and emphasize the fact that such conflict emerges naturally from the difficulties of financing modern medical care and is not indicative of any desire on the part of one group to dominate or control the activities of another. Fears that the commission's recommendations may reflect or lead to "hospital domination" should be allevi-

ated by the presence on the commission of Dr. Larson, Dr. Morris Fishbein and Dr. Paul R. Hawley of the American College of Surgeons—all doctors who are not easily dominated.

Beset as it has been by these problems of philosophy and personnel, the commission has nevertheless been busy organizing its staff and materials for the months of fact finding and evaluation that lie ahead, and initiating a pilot study that is now well under way in North Carolina. Reporting recently to the mid-year conference of state hospital association presidents and secretaries, commission director Graham Davis said the regional conferences had highlighted such problems as the necessity for identifying factors affecting hospital costs, reducing costs, the need for investigating utilization of hospital facilities, the whole area of third-party payments, and hospital public and personnel relations.

ANALYZING THE MARKET

In the North Carolina study, Mr. Davis said, the staff is analyzing the market for hospital services, using the same techniques that industrial organizations employ in their area studies to determine the potential market for specific products. Following completion of this phase of the North Carolina study, problems of production and distribution of health services there will be investigated, he stated. Later, public relations and public education programs will be introduced to test various methods of changing and improving public attitudes toward health service and the utilization of health facilities. "The broad scope and objective nature of the state study have important long-range implications for the better health of the people of North Carolina and the United States," Mr. Davis concluded.

If this is the kind of general assertion that elevates the blood pressure of doctors who belong to A.A.P.S. and similar groups, it is also the kind of forward looking, hopeful expression that gives medical and hospital groups, and the public, their best assurance that the American voluntary medical care system will survive and improve without the kind of radical change everybody fears. The Graham Davises and Harry Beckers of the medical care field are distinguished from its Marjorie Shearons, among other ways, by their belief in Abraham Lincoln's dictum that "the dogmas of the quiet past are inadequate for the stormy present."



The maximum speed of the centrifuge with a full load is 7000 r.p.m.

*A little ingenuity went a long way
in developing this time and money saving*

High Speed Centrifuge

IN 1950 various departments of Paterson General Hospital, Paterson, N.J., cooperated to develop a high speed centrifuge designed to save time and money and increase the efficiency of the hospital laboratory.

The frame of the machine is built entirely of aluminum rods and plates that were precut to size, thus limiting the machine work at the hospital to drilling holes for the machine bolts. The rotors were cast by the Bendix Aviation Company from a wooden pattern carved by a professional pattern maker from a crude drawing supplied by us. The casting was made by the centrifugal method to ensure homogeneity of the metal. The alloy used was a special mixture of magnesium

and aluminum. The precision casting was such that according to Bendix engineers, the castings could stand the strain of up to 35,000 revolutions per minute without special balancing.

MOTOR

The motor of the centrifuge is a $\frac{1}{4}$ h.p. Bodine high speed type that is used on sewing machines (second hand, \$20). The motor is mounted rigidly on the frame of the machine. The shaft of the centrifuge lies against two special ball bearings made by Boston Gears Company. The single bearing pillow was machined in the hospital from a unique piece of brass. This pillow is supported by the frame of the machine through several thick-

RAYMOND JONNARD, D.Sc.
Biochemist

HARVEY M. RADEY
Administrative Resident
Paterson General Hospital
Paterson, N.J.

nesses of soft rubber pads. The interchangeable rotors are carried by the shaft by means of soft rubber bushings. The motor is connected to the centrifuge shaft by a clutch. This clutch consists of a No. 7 solid rubber stopper, bearing two crossed slits, that is clamped to the motor shaft. The stopper fits loosely into a hollow brass cylinder fastened to the lower extremity of the centrifuge shaft. The clutch functions only after the motor has picked up sufficient speed to make the slits on the stopper open enough to increase its diameter. This ensures a good contact with the walls of the hollow cylinder.

A Variac transformer permits continuous control of the speed. Such construction prevents all vibrations from being transmitted from the motor to the centrifuge and conversely; it also makes unnecessary any dynamic balancing of the machine whose various moving parts find their own center of rotation independently of one another.

ROTORS

The machine is provided with two rotors. One is a conical head that will accommodate 12 standard bronze shields for 15 mm. heat-resistant glass tubes held at an angle of 56 degrees. The other is a flat disc, grooved to accommodate 16 Wintrobe hematocrit tubes. The maximum speed of the machine, with a full load, is 7000 revolutions per minute. At that speed it is possible to keep a nickel standing on edge at the base of the machine for an indefinite period of time.

COST

The total cost of the machine was less than \$100. The protection shield was made of a \$6 tin pot from the kitchen. The sound waves produced by this thin-walled pot, because of the suction of air by the centrifuge, had a particularly unpleasant high pitch. Transmission of these waves was prevented by strapping several

tongue depressors to the surface of the pot with adhesive tape. Now a normal telephone conversation can be maintained in the room.

SIZE

The over-all dimensions of the machine are such that it fits into an ordinary refrigerator, thus making it possible to do centrifugations or sedimentations at controlled temperatures.

RESULTS

Hematocrit volumes which normally take from 30 to 40 minutes centrifugation in the usual clinical centrifuge now require only seven minutes. The sharp sedimentation of serum globulin by Kingsley's method requires only three minutes, whereas it formerly took more than half an hour of centrifugation or an equally difficult paper filtration.

The greatest advantage of the machine is the recovery of pathogenic bacteria from dense viscous body fluids. Numerous experiments have shown that in the case of sputum digests, for instance, even one hour of centrifugation at 4000 r.p.m. would leave a high proportion of viable tubercular bacilli (*Mycobacterium tuberculosis*) in the supernatant. Controlled experiments in our laboratory have shown consistently the absence of this organism in the supernatant and their recovery in great numbers in the sediment after 10 minutes of centrifugation at 7000 r.p.m.

SUMMARY

After one year's operation this high speed centrifuge has more than repaid its original cost through time saved and increased accuracy in results of examinations for potassium, sodium, several enzymes, and toxicological investigations, where the extremely fine precipitates produced are usually difficult to recover quantitatively by the usual methods. The frequency of positive findings of TB by this method is approaching that of positive clinical diagnosis. The use of the machine has increased the number of examinations that can be performed by allowing time for such examinations as potassium and sodium which heretofore could not be done for lack of time.

The addition of this machine to the laboratory has indirectly improved the quality of patient care and has demonstrated once again that good inter-departmental relations are essential in any hospital.

VOLUNTEER ACTIVITIES

"1951 Story" Is Worth Reading

"The 1951 Story" of the women's auxiliary of Hartford Hospital, Hartford, Conn., is a 12 page printed booklet illustrated with drawings and photographs. The 1952 story should be just as dramatic, for with Mrs. George N. Jones reelected president things will no doubt continue to hum.

Illustrated on this page is the work of the sewing group, with 24,900 pieces of work to its credit for the year. Thirty-six layettes for use by the social service department were included. Also illustrated is the work of the decorating committee, which last year exercised its taste and judgment in redoing the doctors' lounge, the men employees' lounge, a doctors' conference room near the lobby, three waiting rooms in South Building, the memorial room in the pediatrics department, and waiting rooms in the x-ray and admitting departments.

The Hartford auxiliary calls the cart that each day brings the auxiliary's store to the patient's bedside "The Yankee Peddler." There is a library cart as well, and volunteers also are in charge one day each week in Cheney Library.

Rehabilitation Center

Citizens of Montclair, N.J., have set up a Rehabilitation Center and its location is in the physical therapy department of Mountinside Hospital. The local committee has raised about \$2000. The hospital's auxiliary is active in developing the center, which needs more space and equipment. A part-time secretary has been employed for the physical therapy department

and volunteers are helping. The next step is a training course for volunteers, as the completed center will include occupational therapy as well.

Sets Record Membership

Forty chairmen at church parishes throughout Greater Hartford pound pavements, ring doorbells, and make telephone calls to sign up new members from each individual parish in the women's auxiliary of St. Francis Hospital, Hartford, Conn.

By that method only is the auxiliary able to keep growing, for it lays claim to being the largest organization of its type in the East. Any group that disputes that claim will have to furnish proof of more than 7000 members. It has taken the St. Francis women only 25 years to build an auxiliary from a starting force of 12 determined women to this enthusiastic corps of 7000.

The kangaroo-like strides of the St. Francis auxiliary may be noted also by means of its pledges. In 1926 the women set out to raise \$1000 for the hospital, and they did it. In 1951 the women pledged the sum of \$80,800 to equip the third floor west section of the new maternity and gynecology wing of the lying-in pavilion. This large project has been broken down as follows: \$22,500 for a solarium, \$36,000 for two large nurseries, \$15,000 for two premature nurseries, \$15,000 for a precaution room (to isolate infants feared to have communicable disease), and \$2000 for a linen room.

Cheer Cupboard, the auxiliary's gift shop, is little more than a year old. A snack bar and library are a part of it.

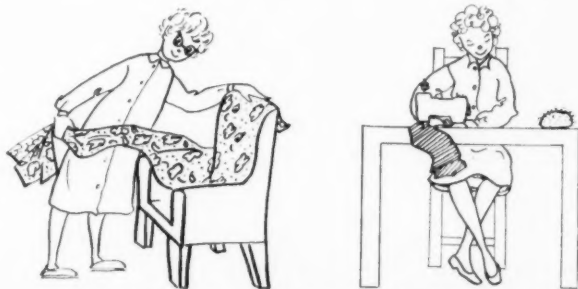


Illustration from "The 1951 Story" of Hartford Hospital

On the Significance of Death

in hospital practice

LIKE his fellow men, the hospital executive is humble in the face of death but, unlike his fellow men, he is confronted with this phenomenon so frequently that he is likely to reconcile himself to its repetition as if it were something that he must accept without question as inevitable. Of all people, the hospital executive must preserve a calm exterior on all occasions and particularly so when he is faced with tragedy which might or might not have been prevented, but he must be a sensitive man inwardly. He may take pride in the thought that the child coming into the world these days can look forward to an average life expectancy of three score and ten, owing, in considerable measure, to the efforts of his hospital and of the medical profession which labors within its walls. However, this does not lessen for him the poignancy of dissolution at any age, whether or not there happen to be survivors to bow in grief for a short time, or for the duration of their days on earth.

IT CALLS FOR CONSIDERATION

The subject of death is often passed over quickly in hospitals in the desire to concentrate on the urgent living business at hand. There is a frequent tendency to regard it as something of a nuisance which must be endured after failure to cure has been registered. Unpleasant and lugubrious though this subject may be, there is every reason for more thoughtful interest in it. Here is a graphic illustration. Ten years ago, in a study which I made in New York City, with a population of 7,500,000 people at that time, there were recorded 76,000 deaths, excluding stillbirths, during the year under review. A great many of these people died in hospitals. Of this number, 8650 were buried in Potter's Field and 882 were assigned to dissecting rooms, comprising together

one-eighth of all deaths. This meant that one-eighth of all those who died in that year were friendless when the final test of friendship was made. These figures are significant in connection with the hospital effort on behalf of the living. Does the administrator, for example, need a better argument than this for the existence of his social service department or, better still, a division of social medicine in his hospital? In the absence of such service can the hospital achieve friendship for the friendless patient?

Further study revealed that the office of the medical examiner for the same city showed 15,824 reported cases. Of this number almost 6000 were classified as violent deaths. Aside from several minor figures, 9000 were classified as natural deaths. Yet the report showed that postmortem examinations were performed in fewer than 5000 cases, or one-third of the total reported. Almost all of these were presumably done on criminal cases. The medical examiner, like the hospital, seemed to be losing an opportunity, and with less excuse!

More than any other phenomenon in hospital life, death, as well as the threat of death, should have a galvanizing effect on the most phlegmatic of hospital servants. It provides a continual and unending series of lessons which nothing else can impress so profoundly or so effectively. The hospital executive can, indeed, be measured by his ability to profit from each experience. Death is a failure of one kind or another, whether or not it could be proved to have been prevented.

Out of long exposure, any hospital executive can recall instances where the supervention of death in the hospital could have come under the legal category of manslaughter, with lesser degrees depending on the extent of malpractice, mostly in the form of

carelessness, which hastened the end. In any situation where clinical judgment dominates the issue of life and death—and judgment of this kind cannot possibly be uniformly infallible—costly mistakes may be made. It would be an unbearable and indeed an unreasonable burden on doctor and hospital executive alike to expect perfect judgment on all occasions, but that this kind of judgment must always be approximated, sought after wherever it can be harnessed, and kept under the closest observation and discipline at all times, goes without saying. There is nothing as final as death, and nothing which history records more deavouringly, however much the victim may have deserved his immortality in Heaven, in Valhalla or in Avalon.

WE CAN ONLY TRY

One might forgive the hospital executive an occasional lapse arising from his personality, education or experience, but any tendency on his part to accept death as a natural phenomenon which requires no further effort or explanation is unforgivable. It depends on his greatest single asset, namely, character. Such an acceptance is a breach of faith with the living who are sick, as well as with the dead who might or might not have survived into an age when the end is more a phenomenon of nature than in the early years. We never can know. We can only try with unexceptionable energy to apply any lesson that might be learned from each incident. This requirement is all the more significant when you stop to think that the emotion of fear is a complication of every diagnosis on the admission of a patient to a hospital.

The prevention of a fatal outcome is the first assignment for any hospital on the admission of a patient. Death must be prevented and postponed at all costs, even if it sometimes thwarts

E. M. BLUESTONE, M.D.

Consultant
Montefiore Hospital
New York City

our efforts after a long and costly struggle, since it is an insidious, ever-present, and implacable enemy. We learn that there are worse things in this world than dying young or dying suddenly. There is such a thing, and particularly so in this era of longer life, as dying on your feet, in a wheel chair, on a stretcher, or in bed, over a ruinous and tragically long period of time.*

LESSON IS ETERNAL VIGILANCE

At what point in the phenomenon of prolonged illness (I prefer "prolonged illness" to "chronic disease" because it is a more hopeful designation) shall we quit the field of battle and surrender the patient to less qualified hands—at a time when he may need the prime facilities of the general hospital most, as is too often the case in our unseemly haste to separate "chronic" from "acute"? According to prevailing "acute" hospital practice this type of "general" facility, the best created by civilized man, is limited in its exclusiveness to those patients who can almost guarantee quick results, one way or the other, while Mother Nature stands by to help, yielding the credit for victory and accepting blame for defeat. Yet no hospital executive can afford to avert his eyes when death looks him in the face, threatening immediate doom or awaiting such an opportunity as the hospital executive might unwittingly create through loss of interest, understanding, helpfulness or resourcefulness. He who yields, and permits his high principles to relax for the briefest moment while life remains, may yield even more next time. The lesson is "eternal vigilance" and anyone who is either too tender-hearted on the one hand, or too hard-hearted on the other, should give way to him

* Shakespeare makes Kent say upon the death of Lear:
*"Vex not his ghost: O, let him pass! He bates him
That would upon the rack of this tough world
Stretch him out longer."*

*"The wonder is he hath endured so long
He but usurp'd his life."*

who is fearless in a good fight and never says die.

Often, when death is imminent, the question arises as to how much it is good to tell the patient. There are some instances where there is something spiritual, if not material, to be gained by telling the patient how matters stand with him as the final shadows fall. However, there are more instances where something is definitely lost. Mistaken prognoses often have exhilarating consequences. We all know the pride that a patient takes in survival, after being told at one time that he had been at death's door. The effect of the announcement on the patient himself must be paramount in our decision. To a lesser extent we must consider the effect on his family and indirectly, at times, on the community in which he moves. If we value courage in the patient we must stimulate and not depress it. If the patient is not conscious he cannot, of course, be told, but we must not be too sure of the depth of his coma, for many a dying patient has heard an intern speak the sentence in his presence, while some, indeed, had the strength left to dispute him.

In each individual case we deal with an unprecedented situation. Sickness is a humiliating experience and death can indeed become a degrading finale for sensitive human beings. Some people go through this world with an acute awareness that the life of every human being is destined to come to an end sooner or later. Preparedness for the end differs in degree among different individuals. Some are always prepared, while others live on as if they felt themselves gifted with a charmed and endless life. Most often the timing of death cannot be foretold with any degree of accuracy. We know only one thing for certain and that is the meaning of age. Collective judgment on prognosis is desirable before any approach is made to this vexing question as to what we shall tell the patient at the end.

An important determinant may be the clinical condition which is killing the patient. If there is a virulent infection, the patient is the victim of an overwhelming toxemia which makes him oblivious to signs and symptoms. If an injury is the cause of death, severe shock enters into the picture. If it is a deformity as, for example, the patient with a congenital defect of the heart, he goes through his short span of life knowing that the end is

at his immediate horizon. If it is a malignant growth that is gnawing at his vitals, he often suspects the worst and it is his problem, in particular, which troubles us most when we ponder the question as to what he may be told.

As we know from the history of war and peace, some patients would have the sun stand still until some kind of victory can be achieved. Others, like the one recommended in Bryant's *Thanatopsis*, "wrap the draperies of their couch about them and lie down to pleasant dreams." Still others in their agony repeat the words of Job, "Let the day perish wherein I was born." Between these extremes one finds all kinds and conditions of men. Some meet the end like heroes, while others tremble at the thought. The hospital executive must be a good judge of human nature indeed to deal successfully with each instance.

DON'T FRIGHTEN THE PATIENT

Many of us working in a hospital have at one time or another considered the advisability of asking antemortem permission for autopsy. In most instances this would be a crude if not cruel procedure which, carried to the limit, might well destroy those very defenses which we are trying to build up in the patient and his family. It is not often that a patient is strong enough spiritually to be told and it is rare indeed that he is strong-willed to the point where he can consider such a step. We might remark at this point that it is preferable to tell the patient the truth than to let him discover his plight by frightening contacts, like the special death-room in the hospital, and the use of heartless designations such as "incurable," "cancer ward," "consumptive ward," and the like.

"Could this death have been prevented?" should receive its answer by the governing authorities of the hospital and the lesson should never be permitted to be forgotten. During the course of any man's illness the process of his restoration to health and usefulness should be helpful to each succeeding patient. In some instances this additional lesson can be learned more convincingly and more productively when the clinical mind is, at the same time, a critical, imaginative and creative mind. Which hospital executive among us has not made this observation, whether or not he is in a position to make the greatest use of it?

When Goldwater penned his famous line: "A deficit is often the symbol of a noble ambition," he must have had more than the financial deficit in mind. He might have been thinking, first and last, of the mortality rate of the hospital which still employs such a figure as proof of hospital efficiency. Yet where is the conscientious hospital executive who does not know that his hospital has parted company with one of its noblest principles when it excludes the sick who are believed to have a high degree of risk and who might increase the death rate of the hospital?

Hospitals surely were not created for curable patients alone, to the total exclusion of the so-called incurable. The incurable patient of today may be the curable patient of tomorrow, as we know from experience, and no medical facility organized by man is in a better position to bring about this result than the modern general hospital. A diagnosis of incurability should never be made, lest we convert a possibly hopeful and curable patient into a hopeless and incurable one. The scientist is essentially an optimist and the doctor is, on final analysis, a scientist.

IT REMAINS A PROBLEM

Nor does a lesson like this fade, rust or disappear with increasing age. The medical problem may vary in its history, duration, complexity or difficulty, depending on recuperative youth or declining age but, in its essence, it remains a problem to be solved. In cases like these, selective interest, tenacity and endurance are prime characteristics for the scientist, alongside of skill and resourcefulness in therapy. He does, indeed, find his best opportunities in the general hospital which limits admissions to only one category of the sick—those who, regardless of age or duration of illness, need the highly concentrated diagnostic and therapeutic facilities which can only be found in such an establishment. Some patients prefer to die at home, in the bosom of their family, to death among strangers in a public hospital—and what a commentary this is on the impersonal and mechanical methods of hospital care!—but this is their personal preference over which the hospital may have no control.

Nowhere does one see the struggle for existence carried on more fiercely than in the general hospital. Patients and their families will clutch at a straw in a frantic attempt at survival.

It is natural, and in keeping with the best traditions of mutual aid, for the hospital executive, among others, to employ every device available in an effort to help. However, since acuteness and urgency wear off before the condition is cured—provided there is to be a cure of any kind—and since illness may continue and not be as demanding in its call for help, the hospital executive must have his ears and all his other senses attuned to a call from the patient which, though subdued, may be quite ominous in its possibilities. High temperature, exsanguination or shock are not the only exciting causes of death. It can, and too often does, occur by a process of attrition, unmatched by the tenacity of the most stubborn doctor. The help which the hospital executive is in a position to give must be active as well as passive and, above all, it must be sustained and unyielding. "Could another doctor have done better?" is a question which every hospital executive must solve for himself and there are times when the answer will lead him into the realm of the highest statesmanship.

There are, of course, accidental deaths, but these must not occur in the hospital through failure of human or mechanical safeguards. The right dose of the right medicine must be administered to the right patient at the right time, but it is not enough to charge up negligence to experience, or to what is playfully referred to in the language of the market place as "profit-and-loss." A death of this kind is more than a sobering experience; it is a reproach, and sometimes much worse! One cannot resist the temptation here to allude briefly to useless, premature or unskillful surgery, done without consultation where there is time to arrange it. It is perverse to argue that the antibiotics, chemotherapy, and the administration of blood and its derivatives can save the reputation of a careless surgeon by their timely administration.

These remarks on a grim subject, represented in theology by an avenging angel with whom we as hospital executives must come to grips, apply with equal force to rich and to poor, for these stand alike in the presence of their Creator in whose image they are said to have been made. More dollars have been contributed to hospitals to aid the friendless and the helpless than were ever contributed out of any other motive. This is in-

deed the basis of the voluntary hospital of our time, yet grief is a painful stimulant to giving, and every hospital executive must take this bit of human psychology into account. Kindness to an obscure and humble patient, who may have no friend to follow him to his last resting place, will continue to have its reward as long as man is willing to accept the rôle of his brother's keeper. In a very real sense the public at large seems forever to be peering through our windows to make sure that what goes on within is in keeping with the best interests of the community.

ADDING INSULT TO INJURY?

The implied threat contained in the question: "Are we adding insult to injury in our hospitals?" compels our constructive consideration. "Are we in our hospitals committed forever to a mechanical form of therapy, often applied to the part rather than to the whole, without regard to human, social and environmental considerations?" If so, we have handicapped ourselves in our race to outmaneuver the angel of death.

The new technics and the new disciplines of social medicine are at hand for the prolongation of useful life, as well as for the immediate purposes of first aid. He who turns away from them is destined to walk in darkness. Death involves far more people than the patient himself, to whom it may indeed come as a wholesome relief from a calamitous life. It can involve these people in an endless chain of sorrow for which time is often the only cure.

It is at the very end, when death strikes in spite of our best efforts, that there is left to us one more task to perform. Having searched our souls for administrative measures that might help to prevent a repetition of the tragedy, we still owe it to the dead, their representatives, friends and neighbors, to explain the fatal outcome in detail while there is yet time, and make the last effort to solve a mysterious process of nature before the mystery is forever sealed up in the earth. The success of the hospital executive in winning the consent of the next of kin to postmortem examination is the measure of his earnestness, devotion and efficiency with vital hospital problems like these and, in the most profound sense of the term, the measure of his usefulness to the community.

TONSILLECTOMY Without Tears

An attractive little booklet prepares parents and children for the experience by means of text and pictures

HOW a modern hospital prepares children mentally for tonsil operations is illustrated by a new child's book released the first of the year by Children's Hospital of the East Bay, Oakland, Calif.

Entitled "Going to the Hospital," the book was designed to help prepare the child for the experience which is usually his first visit to a hospital. According to Richard Highsmith, administrator, the book is part of an over-all hospital program to assist the youngster to take the operation "in his stride."

A copy is given to every tonsil patient at Children's Hospital, usually

several days or more in advance of the operation.

"At Children's Hospital of the East Bay, we make every effort to prevent a child's fear, and to reassure him," Dr. Luigi Luzzatti, medical director, stated. "We think it most important that the child be psychologically prepared for the experience, and this book will help him adjust to it," he said.

MRS. L. A. WILLIAMS

Director of Publicity, Children's Hospital of the East Bay
Oakland, Calif.

While the book is for the child, a detachable insert directed to parents urges them to tell the child why he is going to the hospital, in general what will happen there, how long he will probably have to stay, and other instructions.

The story is about Billy who has his tonsils "out."

On the morning of the operation,

In the relaxed atmosphere of the playroom, young patients awaiting tonsil and adenoid operations play until it is time to go upstairs to surgery.



CHILDREN'S HOSPITAL OF THE EAST BAY



GOING TO THE HOSPITAL



"Hi Patsy! I've had my tonsils out!"

"I know. I missed you last night when you were in the hospital, Bill. I had nobody to play with. Did it hurt you in the hospital?"

about an hour or more before surgery is scheduled, the child is brought to the hospital by his parents, and they go upstairs to the tonsil waiting room. There his mother or father helps the child undress and put on one of the hospital's gowns, then in this pleasant playroom he reads or plays with other

children, who are also waiting, until it is his turn to go to surgery.

The nurse then comes for Billy, and hand-in-hand they walk upstairs to the operating room. He has been told about this room—about the nurses and doctors with masks on, about the tables of instruments, so he isn't too sur-

prised or frightened. The anesthetist or anesthesiologist talks to the child until he goes to sleep.

Parents are permitted to be with the child when he first awakens minus his tonsils. If they say they will visit him at a certain hour later in the day, they are urged to keep the promise.



A nurse took us up in the elevator to a playroom where there were other children and lots of toys and books."

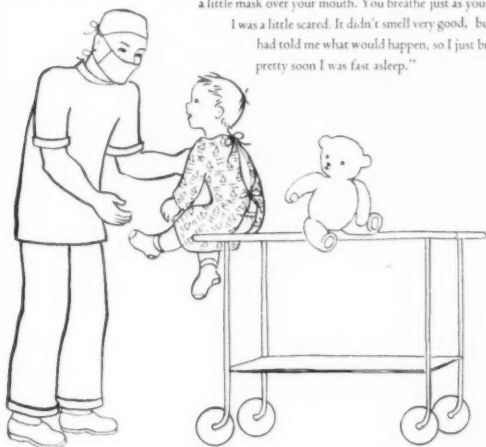
"Mummy read me a story and then I took my clothes off and put on a funny shirt that tied in the back. All the children wear these when they are in the hospital. The nurse took my temperature, then I played some more."



"Then another nurse came in and said, 'Billy, the doctor is here ready to take your tonsils out. I will take you upstairs and your Mummy will wait till we come back.'

Mummy said, 'Good-bye, I'll be seeing you' and I took the nurse's hand and went up to the next floor."

"There was my doctor in a long white hospital coat and a white cloth tied round his head. All the nurses had white masks over their mouths. I climbed up on a high bed and the nurse said, 'I am going to put a little mask over your mouth. You breathe just as you always do.' I was a little scared. It didn't smell very good, but Mummy had told me what would happen, so I just breathed and pretty soon I was fast asleep."



"When Mummy came back I said, 'I feel better.' She said, 'I'm glad' and handed me my teddy bear to keep me company all night. She said, 'Daddy and I will come for you in the morning.'"

The nurse brought all the children ice cream for supper. It felt so good going down my throat. Later she tucked us in and said, 'It's hard to sleep away from home. Tomorrow night you'll be in your own bed.'"

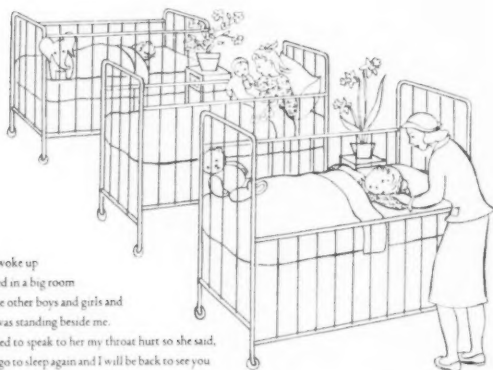
The tonsil patient at Children's Hospital as a general rule stays only 24 hours, going home the following morning.

This experience is woven into the picture-book story which the parent may read to the child. Large pictures are printed black on white, and it is

suggested that the child color the pictures. Paper stock is suitable for either crayon or water color.

Drawings in the book are by courtesy of Mildred Bronson, Berkeley artist, and the original text was written by Elizabeth Elkus of the hospital's Child Development Center, in collaboration

with a committee which included Louise Baker, director of nursing, Dr. Luigi Luzzatti, medical director, Ruth Thomas, director of social service, Mrs. Florence Svenson, head of the outpatient department, and Mrs. E. L. Tucker, the hospital's occupational therapist.

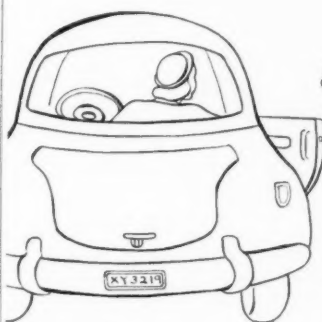


"When I woke up

I was in bed in a big room with all the other boys and girls and Mummy was standing beside me.

When I tried to speak to her my throat hurt so she said, 'Now you go to sleep again and I will be back to see you this afternoon.'

I went to sleep but soon I woke up feeling very uncomfortable. The boy in the next bed was throwing up and I knew that was what I felt like doing, too. The nurse said lots of children throw up after their tonsils are out."



"Next morning everybody was beginning to feel fine again. Daddy parked right outside the hospital. He carried me out to the car and..."

The "Gift Horse" Shows its Teeth

*on the subject of those Christmas gifts,
donations and convention cocktail parties*

A MODERN HOSPITAL ROUND TABLE

MR. JONES: My attention has been called to a very important question, and that has to do with Christmas gifts, or for that matter any kind of bribery. Christmas gift is just a pretty word for bribery, a polite word. The problem is how far you can go on this whole business of entertainment, Christmas gifts, any gift any time, and still not be accused of unethical influencing of a man's judgment.

The entertainment business at conventions has got completely out of hand. I think many dealers and manufacturers at conventions, by countenancing drinking in their rooms with large groups of hospital people until 3 or 4 or 5 o'clock in the morning, are just hurting their own business interests. They are keeping those people from the exhibit floor the next day, keeping them from meetings they should go to. Also, they are exhausting the physical and mental capacities of their own salesmen. I believe that drinking at these conventions has got to the point that something must be done to cure it.

I love to sit down with my friends and have some Scotch, and I have been guilty of staying up until 3 or 4 in the morning or not going to bed at all—take a shower and then go back to work. But I still say the time has come to put some kind of time limit on organized or unorganized drinking in large rooms or little rooms, by large groups or little groups.

VOICE: Who is to blame for all of this entertainment and drinking?

MR. JONES: Both groups, those who take the entertainment and those who give it. And both groups have begun to lose their common sense in the proceedings.

SHOULD hospital administrators, purchasing agents and others with buying responsibilities accept expensive Christmas gifts from suppliers? What about convention cocktail parties and other forms of entertainment? Is it proper for hospitals to ask suppliers for donations to fund raising campaigns? These and other aspects of the hospital-supplier relationship were the subject of a frank round table discussion at the annual meeting of the American Surgical Trade Association in New York a few weeks ago. Here hospital administrators and dealers exchanged forthright opinions on the methods and ethics of hospital buying and selling practices.

Because these problems have long been on the minds of thoughtful hospital people, we thought MODERN HOSPITAL readers would like to "sit in" on this round table; a recording of the discussion was made and will

be presented in this and succeeding issues of THE MODERN HOSPITAL, with the permission of the association.

Taking part in the discussion that is presented this month were: Carl Reisman, Surgical Selling Company, Atlanta, Ga.; Dr. Eugene Rosenfeld, administrator of the Long Island Jewish Hospital at Queens, Long Island, N.Y.; Herbert L. Crowley Jr., Crowley and Gardner Company, Boston; James Best, Cochrane Physicians' Supplies Company, New York; J. Harold Johnston, secretary of the New Jersey Hospital Association; Peter Bozzo, purchasing agent, Columbia-Presbyterian Medical Center, New York, and Corl Chase, Mills Hospital Supply Company, Chicago. Everett W. Jones, vice president of The Modern Hospital Publishing Company, served as moderator of the discussion, which also includes contributions from several unidentified "voices" from the floor.—ED.

VOICE: Do you think for a minute the boys who do that entertaining are enjoying it themselves?

MR. JONES: Some are; let's admit it.

VOICE: It has been pretty much demanded of them for the last few years by hospital people attending hospital conventions, the physicians attending medical conventions, the nurses attending nurses' conventions. Some of them will put the purveyors on notice weeks ahead of the convention: "I'll expect you to furnish so and so."

Believe me, that's the truth.

MR. JONES: I'll agree with you on that. But I would still like to reiterate

the fact that it is a problem for both groups to begin to consider intelligently and take some action on.

VOICE: If hospital people would say they don't want it, it would be stopped quickly enough.

MR. JONES: I would like to see official hospital organizations take a positive stand on it by promulgating rules of order for convention conduct. Then I would like to see the H.I.A. and the A.S.T.A. and other groups do the same thing.

VOICE: When you do it watch how convention attendance will fall off.

MR. JONES: I think it will increase.



Left to right: Peter Bozzo, purchasing agent, Columbia-Presbyterian Medical Center, New York City; Carl Chase, Mills Hospital Supply Company, Chicago; Dr. Eugene Rosenfeld, administrator, Long Island Jewish Hospital, Queens, Long Island, N.Y.



Left to right: Herbert L. Crowley Jr., Crowley and Gardner, Boston; James F. Best, Cochrane Physicians Supplies, Inc., New York City; J. Harold Johnson, secretary of the New Jersey Hospital Association; Carl Reisman, Surgical Selling Company, Atlanta.

MR. REISMAN: As far as the entertaining goes I am going to let "enough said" be enough said. But when it comes to the Christmas gifts, I believe that for every dollar a hospital gives us for merchandise and service we should give a dollar's worth of good, honest value. The customers should have faith in this as we have in our manufacturers. Frankly, we dealers do not have the margin where we get 4 or 7 per cent, or gross profits of 15 or 16 per cent. We don't have margin enough to give lavish gifts at Christmas.

As for its being in good taste, I think we should go back to the spirit of Christmas in bringing glad tidings. I know that manufacturers send us cards and we appreciate them. I think that is about all we can do and should be expected to do—remember the occasion. And I believe that when you start giving fancy gifts it is something which sound business practice, based on giving dollar for dollar, should not consider.

VOICE: I would like to ask what the hospital administrators think on that subject of receiving gifts at Christmas.

MR. JONES: You will get about as many opinions as you ask people. However, the really good administrators do not expect the kind of gift some people give, frankly, to bribe them and influence their opinion. What is good taste I don't know. I would like to have Dr. Rosenfeld, who knows hospital administrators in the East, express an opinion on it.

DR. ROSENFELD: I have been embarrassed more than once by supply houses or manufacturers who sent or brought gifts into my office. I felt, and

I still feel, that when they do that it is a bribe; they are trying to influence me in favor of their company. I don't want to hurt their feelings and I don't want to make enemies. At the same time, taking the gift goes against all of my better feelings.

So I have on occasion refused gifts, and when I have accepted a gift I accepted it under these circumstances, that I gave a gift in return, if it was a personal gift. I would say that if you feel it necessary to give gifts, don't give the gift to the administrator, or to any individual, give it to the hospital. Give the kind of gift that the hospital can use for its patients.

I do think there is a way for the surgical trade to show its good will, but make it in the form of gifts to the patients in the hospital and not to individual administrators or purchasing agents. You put them on the spot. If they have any conscience about things they will feel guilty about taking it. If they are personal friends of yours and you want to exchange gifts, that's something else.

MR. JONES: My guess is that the hospital administrator or the purchasing agent, whoever is doing the job, sometimes indicates he would like a little handout. These things travel fast and it is surprising how many hospital people know who the folks are in their area who go for that kind of thing, and how little respect other people have for them. I believe the salesmen have a great deal more respect for the administrator who plays on the up-and-up with that kind of thing.

That gift to the hospital also has some problems connected with it.

VOICE: May I ask a question? Why

scold us about giving Christmas gifts to hospital people when they put pressure on us to give donations to the hospital?

MR. JONES: That's a point I was going to bring up. There are still too many hospitals, unquestionably, who ask for donations from all the firms they are doing business with, whether they are in the same town or not. I think a hospital in a city has as much right to ask the local surgical dealer or manufacturer for a donation as it has to ask anybody else in the same town. But the minute that hospital starts asking people outside of the immediate area, that is nothing in the world but blackmail.

VOICE: If you don't give, you don't get an order.

MR. JONES: I saw a letter written by a hospital out in the Midwest to a manufacturer in the East asking for a donation to the hospital fund raising campaign. The company wrote back and said, "Sorry, we don't make a practice of doing that. We do support the hospital in our home town, but that is as far as we can go." That hospital superintendent wrote back a very nasty letter. He said, "You had better contribute to this campaign if you want our business," and that is about as bald as the letter was.

MR. BEST: I don't think any hospital has a right to ask any dealer who is treating it fairly as far as price and quality are concerned for any donations whatsoever.

MR. JONES: Why not?

MR. BEST: The only reason a hospital has any right to ask any dealer for a donation is when the manufacturer has a large plant in a small town

and the dealer is furnishing the hospital and the hospital is taking care of the manufacturer's employees.

MR. JONES: What you are saying, then, is that the hospital in any community hasn't the right to ask anybody in that community to help build a new wing.

MR. BEST: I didn't say that.

MR. CROWLEY: There is another problem. I don't know how many hospitals there are in New York City, but suppose they all went to the dealers and said they wanted \$50, or something like that. How are we going to determine which one of those hospitals should get the gift?

MR. JONES: The way the manufacturers are beginning to handle this problem is by studying the number of admissions per hospital. They give on the basis of the number of patients the company had in the hospital within the last year, compared to the total number of patients. Ford, for instance, has that problem, and so does General Motors. They have plants in many cities and they support the hospitals in the towns where they have factories, based upon the use of the hospital by their employees, which I think is fair.

MR. JOHNSTON: Can I tell a story? I think you will find it as amusing as I did. I am the secretary of the New Jersey Hospital Association. A few months ago we had a letter from one of our hospital members asking us for a contribution toward its new wing. I checked through on it, called the ad-

ministrator and he said he didn't know anything about it but a committee from the board of trustees had gone through all the accounts payable. They had found that we were a supplier in a sense because the hospital had paid dues to the New Jersey Hospital Association, and that is why it was all right to ask us for money.

Of course, I realize the problems you are up against in dealing with these people, but don't be suckers. If the hospital is outside your area—I feel very strongly that you should not have to contribute to it.

I am inclined to think the problem isn't as great as it was 35 years ago. These people have realized it is not fair, simply because you are selling supplies to them, that you should have to take part in their building fund when the hospital is not in your own area and serving your own employees.

VOICE: You say it isn't prevalent. I just got a letter from a hospital administrator saying he understood all surgical dealers made so much money we had excess profits and he would, therefore, appreciate a contribution of from \$1000 to \$2000.

MR. JONES: Was that outside your immediate area?

VOICE: It was 450 miles away.

VOICE: I was wondering how far we might go with this Christmas present idea. I, for example, go out to a hospital superintendent who has been giving me a certain amount of business over the year and maybe leave him a

bottle of liquor or some type of a present and say, "Thanks very much for the business you have given us in the past," and that is a matter of appreciation for what he has done during the year. Do you think that is wrong?

MR. BOZZO: I would say it would depend entirely upon your personal relationship with the administrator. If you are giving to him simply because of the valued business he gives you I would say you are wrong. If you like him personally and you want to make a gift of your own accord, then I would say there would be no objection to it.

I have lots of people come up to see me and leave a gift. I like them personally and accept it and say thanks. On the other hand, I have people come up who want an "in" and I say No and refuse it with many thanks. Along those same lines, I, like many other purchasing agents, receive a lot of small stuff. Last year I got something like a dozen cigaret lighters. Needless to say, I gave them all away.

If you want to spend the money, don't spend it on us. Give it to some kids in the hospital who would certainly enjoy a toy a lot more than we want a dozen lighters.

MR. CHASE: You would be surprised how many purchasing agents and superintendents come out flat-footed and ask you what you are going to give them for Christmas.

MR. JONES: I wonder if that is a high percentage of the total or only occasional.

MR. CHASE: It's too high.

VOICE: I think he is talking to the wrong group; he ought to talk to the hospital administrators and purchasing agents.

MR. JONES: They have been talked to on many occasions.

VOICE: A letter came to us not long ago. I think we had sold this hospital \$5 worth of tubing and our name was on the list. They sent the letter to everyone on the list. The administrator or the purchasing agent or someone gives the purchasing list to the nurses' association, and you get a request to please send a contribution for a page in some program they are having. We have all those things to contend with. We get about a dozen such letters a week.

MR. BEST: Don't forget that in this Christmas present, or graft or what you will, there are always two parties involved, one who gives it and one who takes it, so I don't think you can split the responsibility.

TIME TO CHANGE SIGNALS

SIGNAL systems in hospitals have thus far been of the active rather than the passive type. Yet we need both, if we are to take good precautionary care of our patients, especially at times when nurses are in short supply or when the patients whom they serve are decentralized and helpless in separation rooms.

As matters now stand, a patient who requires service may press a button which will bring the nurse to his bedside—provided, however, he is able and willing to use this device. But, suppose that he is unable or unwilling to use this device? Suppose he decides to take matters into his own hands and steps out of his bed, unaided, to seek relief? If the nurse is not continuously on the alert, she

might or might not respond to the emergency. In any case, there is an element of chance, with which every hospital executive is only too familiar from bitter experience.

What I am suggesting here, is the installation of a passive as well as an active signal system by which a response will be forthcoming as soon as a patient leaves his bed. This can be installed on the burglar alarm principle, placed strategically, and made sensitive without regard to the use of the active signal which is kept at the hand of the patient in bed in the hope that he will cooperate. Signals like these are on the horizon. We need more of them.—E. M. BLUESTONE, M.D., consultant, Montefiore Hospital, New York City.

The Essence of Public Relations

ENLIGHTENED CONDUCT—ADEQUATELY INTERPRETED TO THE PUBLIC

F. GORDON DAVIS

Public Relations Counsel, Birmingham, Mich.

SOME time ago, 2000 of the nation's leading public relations executives and practitioners were asked to define what public relations meant to them, and then a committee of nationally known experts chose the best definitions from the lot. The definition finally selected as best reads as follows:

"Public relations is the continuing process by which management endeavors to obtain the good will and understanding of its customers, its employees and the public at large; inwardly through self-analysis and correction, outwardly through all means of expression."

I think that it can be and has been expressed much more simply than that. The definition of my choice, whose author I unfortunately do not know, says simply, "The essence of good public relations is enlightened conduct, adequately interpreted to the public."

TWO MAIN POINTS

Notice, in any event, that both of these definitions have two main points. Using the terminology of the second definition, the first point is "enlightened conduct," and the second point is "adequate interpretation."

Public relations has developed as a sort of science because in an organized society we lose contact with all those persons upon whom we are dependent for our own well-being and who, in return, may be dependent upon us in varying degrees.

Condensed from a lecture presented at the Frances Payne Bolton School of Nursing, Western Reserve University, Cleveland.

When we lose contact, we often lose mutual understanding. Worse still, we are likely to become so busy with our own direct responsibilities that we don't even know we have lost contact. Wholly unconsciously, we may start doing things that other people do not understand. We may even start doing things that offend.

MAY BE TAKEN FOR GRANTED

And so we find that the work we do at best is accepted by others with indifference or taken for granted, and at worst it arouses antagonisms and resentments. We find that the institutions or the agencies we represent may lose friends or even create enemies. We find that the whole field of endeavor with which we have identified ourselves—whether it is nursing, hospital administration, the conduct of a public utility, or the manufacture and selling of a given commodity—does not impress people as favorably as it should or it actually begins to lose public esteem. These things can happen not because we are failing to do our jobs well, but because we are failing to study the ways in which our jobs affect other people and to take definite action to procure the understanding of others.

It is given to few of us to be objective. Try as hard as we will, we cannot look upon ourselves as others look upon us. This is why public relations must begin with great emphasis on "enlightened conduct." Nor can we afford to assume that enlightened conduct automatically results from right living any more than we can assume that our health will take care of itself if we leave it alone. Like health, en-

lightened conduct requires positive action. It means not only that we make certain we are doing our best to do our job well, but also that we make certain our best is succeeding.

Perhaps we can convert this statement into one of the 1, 2, 3's, or the A. B. C's, of public relations, as:

1. Recognition of the problem.
2. The development of solutions.
3. The introduction of the solutions

to the employees or the subordinates who are supposed to make use of them in dealing with the public.

How do we discover the problem in the first place? I have indicated that many of our most serious public relations problems arise almost completely without our recognition of them. Most of the great growth of unionism in this country during the last 15 years, for example, has been brought about by employers who did not recognize that they had problems in personnel relations, which is one form of public relations.

ARE WE CAUSING ANNOYANCE?

We discover where our public relations problems lie by never taking it for granted that we are doing a good job, no matter how hard we are trying to do so. We subject ourselves to self-examination, to soul-searching. We wonder whether people really are accepting our conduct as we hope they are accepting it, or whether somewhere along the line we are unnecessarily causing annoyance, resentment or outright hostility.

There are many technics of self-examination. The easiest and most obvious consists merely of taking the time ever so often to submit your con-

duct and the conduct of your subordinates to intelligent, critical review. We can do much along this line by making a point of talking to the humblest persons who are affected by our activities. By talking in a friendly way, by the tactful posing of questions, and by close observation of their reactions, we can learn a good deal about the way in which our product, whether it is a service or a tangible commodity, is being received in the market.

All of us get too busy to do these things, I know. That is the reason we have public relations as a separate specialty. If modern society did not impose so many demands on our time and our thought processes, we would be good neighbors without ever giving the matter a second thought. Because we are busy, however, we are likely to assume that things are going along all right. Then one fine day we wake up to find that we have an open rebellion on our hands, and that perhaps it has progressed beyond the point at which control of the situation remains in our own hands.

COMPLAINTS ARE IMPORTANT

A word about complaints: It is amazing how many organizations leave the handling of complaints largely to the discretion or the intuition or the moods of subordinate personnel. In some of our biggest businesses and institutions, top management never has contact with complaints except those few that more or less inadvertently by-pass the rest of the organization.

This gives the boss a wonderful feeling of security, undoubtedly. Everything is right with the world because he hears little about dissatisfaction. He can't understand it when, after years and years of uneventful business activity, a decline in sales or a strike of employees or a public clamor for legislation to govern his practices breaks right out of a "clear" sky.

If you are in a supervisory capacity over subordinates dealing directly or indirectly with the public, do you have an organized or regular—and I stress the word "regular"—system for reviewing public complaints? Or perhaps "complaints" is too restricting a word. Public suggestions, public comments on the work you are doing can be fully as valuable as expressions of dissatisfaction, and in a truly progressive organization these latter normally will far outweigh the protests.

These indicators of the way the public winds are blowing should be studied carefully and individual action taken wherever it is indicated. Moreover, they should be classified so that you can very early begin to detect the emergence of certain revealing patterns. The patterns are the guide posts by which a fundamental part of your future progress should be charted.

There are many instruments of self-examination and self-criticism. Employee suggestion systems constitute one such method. By this I do not mean the mounting of a box labeled "suggestions" in the locker room or beside the bulletin board, there to catch an assortment of gripes and wisecracks which have no bearing on general working conditions, personnel relations or public contacts. A sound suggestion system needs to be carefully thought out and well organized. Many of the most effective systems in operation these days are coupled with incentives in the form of awards or percentage shares in resultant savings.

Another method of self-analysis is based on the use of surveys or opinion analyses—studies of the opinions of employees, of informed friends of the organization in question, of customers, of the public generally. These surveys are conducted in many different ways, sometimes by letters, sometimes by mailing double postcards to carefully selected lists, sometimes by enclosing questionnaires in literature, sometimes by personal interviews conducted by outside organizations skilled in basic survey techniques.

Soundly conducted surveys of this nature are extremely valuable instruments in the public relations field. It is not necessary that they be accurate within a fraction of 1 per cent—not for the guidance of management in its ordinary functions, at least. What we need to know in setting up a public relations activity is the general level of public information and the

general trend of customer and public attitudes. An error of a few percentage points one way or the other may completely change the results of an election, but it is hardly probable that it would greatly influence a public relations program.

The public relations of the nursing profession merits an extremely high rating, and in fact receives it at the hands of the public. I am not guessing; I have the facts on which to base that assertion.

One of my public relations assignments was conducted in Michigan through an organization which we called the Michigan Health Council. In order to know the nature of the job ahead of us and how to handle it, we employed a research organization to interview 10,000 persons scientifically selected to represent an accurate cross section of the entire population of the state. These persons were interviewed in their homes and on their jobs, and they were asked 28 primary questions and many additional subordinate questions designed to yield an accurate reflection of their thinking.

One of the questions went something like this: "If you are or were a parent, would you advise your daughter to become a nurse?" The purpose of that question was, of course, to determine whether people thought highly enough of nursing to endorse it as a career for their own daughters. More than 80 per cent of the persons interviewed answered this question with a resounding "Yes."

CHECK UP ON THAT FIFTH ONE

We do not conduct public relations surveys in order to collect a file of flattering opinions about ourselves. The high rating given to nursing by the public constitutes a piece of practical information. At the same time, the vote was not unanimous, and it never will be unanimous. We should be glad to know that four out of five persons would recommend nursing as a career for their daughters, but we should be far more interested in knowing why one out of the five would not make this recommendation. We should, in other words, investigate the complaints.

Is the negative vote because of economic or social conditions? Is it because some parents consider the profession of nursing unworthy, or unstable, or lacking in prestige? Is it because they believe that the work is



too rigorous or the opportunities are not great enough?

While I believe that nurses care considerably what the public thinks about them, let us assume for the moment that they do not care. Let us assume that all they want is to be allowed to do their work as best they can, and that they don't consider the moral backing of favorable public opinion at all essential to this purpose.

The fact remains that isolationism within a single organization or a single profession is as impossible as it is among nations. As a matter of direct proof, an intensive program for the recruitment of student nurses has been necessary for a number of years and undoubtedly must continue well into the future. If this program is to yield the most productive results in relation to the effort, public attitudes toward the profession are vitally important.

Public disfavor usually is based on two influences: the existence of popular misconceptions or misunderstandings, and the existence of conditions in need of correction. Once public thinking has been tapped, the ensuing course is obvious. It calls for public education to eliminate misunderstandings, and for the correction of conditions which have resulted in justifiable criticism.

CONDUCT COMES FIRST

In other words, we are still dealing with the problem of enlightened conduct as the first prerequisite of a good public relations program. If the necessity of enlightened conduct is not clear from the previous discussion, it may be seen in the story of the president of the small electric power company who was extolling the company's virtues at a public meeting.

"If I may be permitted a play on words," he concluded with a flourish, "I should like to refer to our work as the triumph of the Light Brigade."

Immediately a voice rang out from the audience, "Oh, what a charge they made!"

That power company, we may assume, was undertaking interpretation without enlightened conduct.

The fact is, there are times when it is foolhardy to undertake any sort of program of public education until your house is in order and you *know* that it is in order. Again, the exigencies of the particular situation may not permit us to undertake all of the house cleaning we would like. New needs, like neighbors, may drop in unexpected-



edly. We have to do something to meet them even when our action involves going before the public, but we should make every effort at the same time to be certain that we are morally justified in asking for the confidence and the support of the people.

People who make a business of public relations are needed. In planning broad or extended campaigns, for instance, professional help usually is needed somewhere along the line. Again, the essential elements of time, experience or objective point of view may not be available to the person or agency responsible for cultivating public good will. Most of us can do a better job of public relations in our immediate spheres of activity regardless of the technical aspects of the business. We can try to recognize the public relations problems that confront us individually and that affect the work we are trying to do. We can try to work out the solutions to those problems. And we can try to put those solutions into practice.

To a large extent, we do these things *instinctively*. They are part of the process of getting along in our society. But if we do them *deliberately* and thoughtfully, if we charge ourselves consciously with the duty to be public relations emissaries in our everyday jobs, improvement in the results is almost certain to follow.

The interpretive side of public relations—that is, the side of public education—could be discussed at great length. Many or all of the elements involved in this—literature, publicity, direct mail, speeches, displays and exhibits, advertising and so on—may be used in a broad or prolonged program. Some of them are essential in any educational effort. They are, after all, merely means of communication, and we make use of those best suited to the purposes we have in mind.

Beyond this, I doubt that this is the place to talk about how to tackle problems of adequate interpretation. I cannot say how nursing literature

should be written or how to develop stunts, or where to place the emphasis. Those will be arrived at only by dint of study, thought and reasonable effort on the part of the nursing profession.

Some nurses undoubtedly never will be called upon to formulate a public relations program as such. Nevertheless, public relations is a matter of concern to all responsible members of the nursing profession.

Now watch out! In order to conclude this discussion, let us assume that our immediate project is to develop the best popular understanding of the profession of nursing. Presumably the starting point is with a definition of nursing for which you wish to gain public acceptance.

WHAT MAKES THEM DIFFERENT?

Maybe you have such a definition. As an interested outsider, however, I would say that you do not. Other than the completion of certain academic requirements, for instance, how do you distinguish a practical nurse or a nurse assistant or a nurse's aide from a registered nurse? What is it specifically that sets the qualification of the registered nurse apart from all other persons? What does the specialty mean to the public in terms of service that can be obtained nowhere else?

What is it that a nurse seeks from her profession? Is it money, or is it recognition and prestige, or is it the opportunity to serve humanity? Is it a combination of these things?

I am sure all nurses know the answers to these questions within themselves, but can they be interpreted to the public in a reasonably concise definition that you are willing to accept as the basis of a long-range, permanent public relations program? It seems to me that the mere process of trying to think out a definition—of trying to classify your knowledge as it pertains to nursing so that people will have a sort of inspired understanding every time they hear the word "nurse" used thereafter—is almost an end in itself.

The fact that you think about the significance and the meaning of your profession as it relates to other people, and that you think deeply in this direction, will enable you not only to be better at your own work but also to interpret it more effectively to others.

That—enlightened conduct plus adequate interpretation—is good public relations.

About People

Administrators

Dr. Harold C. Lueth, dean of the University of Nebraska College of Medicine and administrator of University Hospitals at Omaha since 1946, has resigned those positions effective next June 30 and will enter private practice in Evanston, Ill., after that time. A diplomate of the American Board of Internal Medicine, Dr. Lueth will also teach clinical medicine at the University of Illinois College of Medicine in Chicago.

A graduate of Northwestern University Medical School, Dr. Lueth practiced internal medicine in Evanston before entering the army medical corps in 1940. During the war he served as liaison officer for the Office of the Surgeon General at the American Medical Association headquarters in Chicago and, later, in the personnel department of the Surgeon General's Office in Washington, D.C.

Dr. Lueth has been active in medical and hospital associations. He has been a member of the A.M.A.'s council on national preparedness and served as chairman of the A.H.A. council on education. He is a past president of the Nebraska Hospital Association and was to have been president of the Mid-West Hospital Association next year.

J. B. Franklin has assumed his duties as administrator of the new 200 bed Washington County General Hospital, Greenville, Miss., which is expected to be opened in early fall. Mr. Franklin formerly was administrator of the Tallahassee Memorial Hospital, Tallahassee, Fla., and the John D. Archbold Memorial Hospital at Thomasville, Ga.

Evelyn M. Sorenson, R.N., has been appointed administrator of the DeWitt Community Hospital now under construction at DeWitt, Iowa. Miss Sorenson was formerly superintendent of the Good Samaritan Hospital at Sheldon, Iowa, and also at Oakland Memorial



Dr. Harold C. Lueth

Hospital, Oakland, Neb. She also has served in the Alaska Native Service, stationed at Sitka, Alaska.

Dr. Glenn T. Dewberry has been named superintendent of the Western Oklahoma Tuberculosis Sanatorium at Clinton. **Dr. Paul Lingenfelter** has been serving as acting superintendent of the sanatorium since **Dr. D. L. Coffman** resigned to become head of the Weaver H. Baker Memorial Tuberculosis Sanatorium, Mission, Tex. Dr. Dewberry formerly was assistant superintendent of the Arkansas State Sanatorium at Booneville and earlier he was associated with a tuberculosis sanatorium at Evansville, Ind., for two years.

R. O. Daughety has resigned as director of City Memorial Hospital, Winston Salem, N.C., to accept the post of director of the University Hospital, Augusta, Ga.

Elizabeth Earle has resigned as superintendent of the Wallace Thompson Hospital, Union, S.C. She has been associated with the hospital for about 30 years. **Veta Hughes** has been appointed acting superintendent of the hospital.

Cyrus Eaves is the new administrator of George County Hospital, Lucedale, Miss., succeeding **May Whitlow, R.N.** Mr. Eaves is a laboratory and x-ray technician. Miss Whitlow succeeds **Sarah Smith, R.N.**, as administrator of Greene County Hospital, Lakesville, Miss. Mrs. Smith is the new superintendent of nurses at the Wayne County General Hospital, Waynesboro, Miss.

J. M. Cooke has been appointed administrator of Roseland Community Hospital, Chicago.

John M. Duggan and **Sydney C. Peimer** have been appointed administrative assistants at the Jewish Hospital of Brooklyn, Brooklyn, N.Y. Mr. Duggan is a member of the American Hospital Association.

Francis M. Petrie has been appointed director, Westerly Hospital, Westerly, R.I. Mr. Petrie is a 1948 graduate of the class in hospital administration, Columbia University School of Public Health, and has been administrative assistant at Brooklyn Hospital, Brooklyn, N.Y.

Raymond F. Hosford, administrator of the Bradford Hospital, Bradford, Pa., for the last 20 years, has been named director of Lankenau Hospital, Philadelphia. The former director, **Daniel E.**



D. E. Gay



R. F. Hosford

Gay, has been appointed special consultant to the board of trustees. Mr. Gay will devote full time to directing completion of the new Lankenau Hospital.

Mr. Hosford, a past president of the Hospital Association of Pennsylvania, was also president of the Northwest Regional Association, which he helped organize. He is a member of the boards of the American Red Cross, the American Cancer Society, the McKean County Tuberculosis and Health Society, and the Bradford Community Council of United Community Services.

Before going to Lankenau Hospital Mr. Gay was administrator of the Phoenixville Hospital, Phoenixville, Pa., for four years. He is a member of the American College of Hospital Administrators and of the American Hospital Association, president of the Philadelphia Hospital Association, and chairman of the council on hospital association development of the Hospital Association of Pennsylvania.

Carl M. Westhoff is the newly appointed administrator of the Wabash General Hospital, Mount Carmel, Ill.

Taylor O. Braswell has assumed the duties of administrator of Fairfield Memorial Hospital, Fairfield, Ill., succeeding **Alfred Van Horn III**, who resigned to accept the position of assistant executive director of the American College of Hospital Administrators. Mr. Braswell received his master's degree in hospital administration from Northwestern University and served a one-year administration.

(Continued on Page 182)

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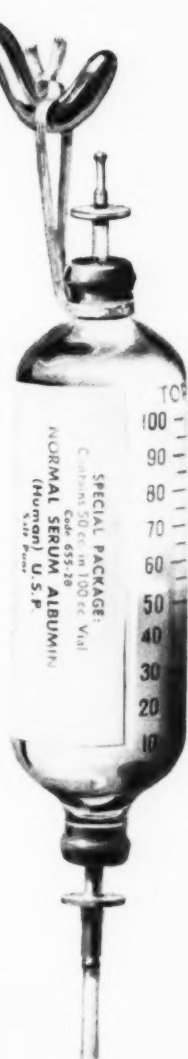
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Which is it to be —

COOPERATION or COMPULSION?

the choice rests with doctors and hospitals

FREDERICK T. HILL, M.D.

Medical Director
Thayer Hospital
Waterville, Maine

IT IS indeed unfortunate that at this time there appears to be a growing rift between the two great groups concerned with the health of our people. Faced by the threat of government bureaucratic control, under the program advocated by certain powerful political forces, hospitals and the medical profession should be standing together, shoulder to shoulder.

SCHISM WOULD BE TRAGIC

Both groups, by their combined efforts, have made possible in this country the highest type of medical and hospital care in the entire world. Tragic, indeed, would be the result of any schism, not only to medicine and our voluntary hospital system, but to the country as a whole. Yet largely because of a sort of malady, rampant in the world today, which threatens to undermine much of our social structure, this could come to pass. The insidious character of the disease is often unrecognized, and its effects little realized. We have come to look with apprehension upon the tendency toward the increasing centralization of power which leads to the totalitarian state, examples of which are all too evident today. We recognize the evils of such a system, with loss of individual liberty of thought and deed, and decry efforts to promulgate such a condition here. Yet the virus of this disease seems to have penetrated our own ranks, infecting persons and groups who by background and tradition should be immune. This has resulted in dissension and dispute where there should be harmony, and in the tendency to adopt technics and procedures which should be unheard of among people of our professions.

One has only to consider the present conflict between our hospitals and

some of our medical groups over what is generally referred to as the Hess report, to confirm this statement. Fortunately this conflict has been rather localized and has not as yet reached epidemic proportions. But should this virus be allowed to go unchecked, we may face a condition which carries a morbidity, crippling in its effect. And, as is the case with most viral diseases, should there be a secondary bacterial invasion of government intervention, American medicine and the voluntary hospital, as we have known it, may well succumb.

All this seems so unnecessary. For, as Dr. Wilinsky so eloquently phrased it, "Men of good will, motivated by ideals consistent with the altruism of the medical profession, as well as those concerned with the advancement of hospital practice and service, should be able to meet and resolve these problems."

In listening to discussions of this problem, both in medical and hospital groups, and in studying the many published reports, it would seem that the major difficulty has been in a lack of mutual understanding, possibly a deficiency in communications. This, in itself, tends to breed suspicion, fear and distrust, in turn leading to assertions which may be fallacious, and charges which seem baseless. And worst of all, we seem to be in danger of losing sight of what should be our main objective, the best possible care for the patient.

Not so long ago I sat in a meeting of one of our national medical societies which was devoted largely to a discussion of this matter of hospitals

and the practice of medicine. Most of the remarks were frankly condemnatory of the hospital. Now these were all "men of good will," representative of the best in the profession, and I am sure, with no personal "axes to grind." Obviously there was a great deal of misapprehension and misunderstanding which careful study and cool judgment would eventually dispel. But, most disturbing of all, never once did anyone refer to the person most concerned, the patient.

Similarly I have sat in on discussions with leaders in the hospital field and have listened with distress to voiced suspicions and implications attributed to members of my own profession.

THERE MAY BE A REASON

Perhaps there may be a reason for this misunderstanding, deplorable as it is. The tremendous progress made in the past few decades, both in medicine and in hospital development, has resulted in a radical change from a relatively simple institution to the highly developed and necessarily complicated hospital of today. This change, beneficial as it has been, inevitably has led to certain problems, largely those of human relationship. Perhaps much of this dissension may be due to "growing pains." But, if we are to attain maturity, it would seem necessary for both hospitals and medicine to recognize that they are dependent each upon the other, and that neither could have reached its present high status alone.

With the development of scientific medicine there has come an increase in specialism far beyond anything contemplated in earlier days. Many of these newer specialties, being investigative or diagnostic in character, or largely ancillary to the definitely clin-



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ical fields, necessarily have been incorporated in varying degree in the hospital structure. Naturally this has resulted in a different basis for remuneration than where there existed a direct patient-physician relationship. Charges have been made that these specialists have been exploited by the hospitals. Possibly this may have been so in the past when these specialties were in the formative stage, so to speak, and their value not fully recognized. But today the law of supply and demand would seem to have disproved any such charge. The status of these specialties is so secure today that it should be possible to arrive at a form of compensation, equitable both to physician and to hospital at the local level, without attempted dictation from some higher echelon, whether it is representative of medical groups or of hospitals. Collective bargaining should not be necessary among scientific persons unless we are prepared to accept a completely unionized state.

CHARGES BECOME DISTORTED

Much harm has been done by charges and arguments on both sides, often by irresponsible individuals. Too frequently these become distorted and exaggerated as they are passed on from person to person.

For example, one hospital administrator, faced with a mounting deficit, is said to have advocated charging the surgeon, in addition to the patient, for the privilege of using the operating room. As might be expected this engendered considerable hostility in certain influential quarters. While efforts to balance his budget seem laudable, this plan was so fraught with implications as to be utterly ridiculous. The next step might be to farm out concessions, like the hat-check girl in the night club, throughout the hospital. Soon all requirements of professional competency might be replaced by the ability to buy privileges.

While it may seem a minor matter, the use of the term, "employee of the hospital" in many Blue Cross contracts has been unfortunate when referring to professional services rendered by physicians. Doctors, understandably, are proud of their professional status and resent anything that in any way threatens it. The implied classification with technicians has been distasteful, to say the least, and has been something of a factor in this problem.

These past few years have seen the

development of hospital administration as a profession with more and more the lay administrator replacing the physician executive. Undoubtedly this has been a cause for the fear of lay domination of the hospital. By training and background the lay administrator often is closer to the trustees than is the doctor, who often tends to live in a world apart, and who jealously resents any intrusion into what he rightly considers his own domain. Again, this is largely a matter of misunderstanding. The modern hospital of today requires much more than a medical background for successful administration. Hospital administration is a profession and we physicians should recognize it as such. The capable administrator is one who is cognizant of the scope of his field, and of its limitations. In medical matters, pertaining to the professional care of patients, he will look to his medical staff for guidance. The one who does not do so cannot be considered qualified and ultimately will find there is no place for him in the profession. Mutual understanding and cooperation between physician and administrator should dispel any such fear of lay domination.

As a physician engaged in clinical practice my sympathies naturally tend to be with the medical profession. Yet, as a physician, I deplore the tendency in certain quarters to use the techniques of pressure groups so commonly seen today in labor difficulties. Are we to adopt the closed shop, collective bargaining, and the adherence to a formula for compensation set by some higher echelon speaking for the rank and file? The threat of disapproval for the training of residents and interns has certain earmarks of a boycott, if not a strike, possibly with a psychological picket line in the offing. Aren't we in danger of losing our prized professional status, becoming merely a trade, of really meriting the label with which certain forces have attempted to brand us? For if this attitude continues it might well extend to the whole profession.

We hear of attempts on the part of certain groups to expel from membership, on the grounds of unethical conduct, members of medical school faculties because of serving full-time on a salary basis. We are told of instances where young specialists desiring to qualify for their boards have been advised that they could not be considered if they continued to work

on a salary basis, even though that basis was perfectly satisfactory to them. Is that a proper function of a board, supposedly designed to determine professional competency?

Of course, these are isolated instances and do not reflect the attitude of the medical profession as a whole, but, because they have occurred and have been more or less widely circulated, they have done considerable damage in the eyes of the public.

Actually the much-discussed Hess report itself, when carefully studied, hardly seems to merit all of the attention that has been accorded it. It does state that a physician should not dispose of his services to any hospital under conditions which permit of exploitation for the financial profit of the institution. And it does embody a procedure for the correction of exploitation which properly originates at the local level.

DON'T FAVOR EXPLOITATION

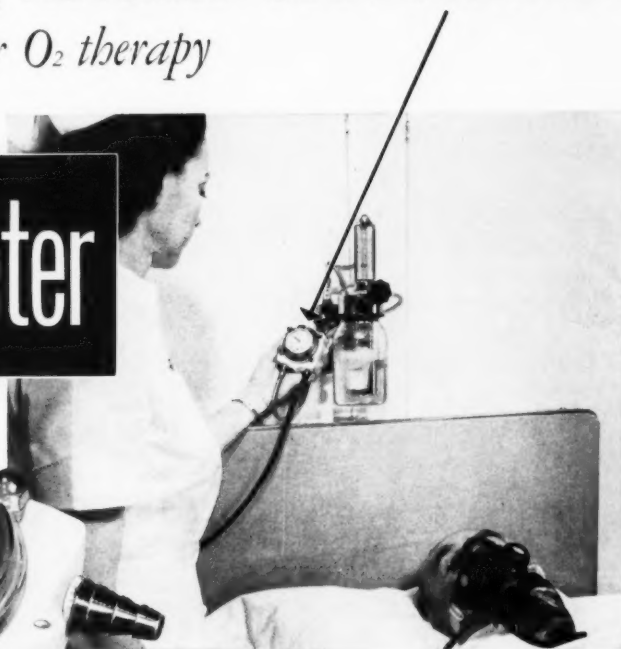
The real danger is in the interpretation of the report and the use made of it by what might be termed pressure groups. Of course, no hospital or no physician would favor exploitation of anyone. The difficulty would seem to be in determining what constitutes exploitation. Certainly a method of compensation mutually satisfactory to both parties could hardly be called exploitation. A rigid over-all formula, determined by some higher body, would seem more in the nature of exploitation, at least of the patient who eventually pays the bill, than some mutually agreeable plan settled at the local level.

The implication that a hospital should not use any profit made from one department to provide needed services in another is, of course, disturbing; and, if enforced, would simply add to the already excessively high bill the patient must pay. Carried to a logical conclusion this would seem to indicate that certain services should be discarded, no matter how necessary or life-saving, unless the cost could be met from patients' fees for these particular services.

It seems unfortunate that so much emphasis has been placed upon the matter of ethics. Ethics, as I understand it, is the science of morals. Does the basis of compensation, if mutually satisfactory, raise any moral issue, except when the welfare, economic or physical, of the patient is jeopardized? Likewise, attempts to question the

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legality of the hospital employing full-time physicians and collecting fees for their services have caused considerable confusion. On one hand we are told that the employment of a physician on a salary or percentage basis, with the accrual of any part of the fees earned by the physician going to the hospital, constitutes the practice of medicine by the hospital and as such is illegal. On the other hand Robert Cutler, himself an outstanding lawyer, disputes this, stating that this "overlooks the basic conception of corporation law,"² and citing precedents and examples of similar financial relationships between members of his own profession and corporations. Of course, in these days of social turmoil, legal precedents may not stand for long, but any such change could not be expected to be confined to one profession and would indeed usher in a new era.

IT'S AN ECONOMIC PROBLEM

Careful consideration of this problem would seem to indicate that it is largely an economic one. At least it can appear little else in the eyes of the general public which could have scant appreciation of the sometimes liberal application of the word "ethics" as used in medical circles. Similarly it could be difficult to convince many laymen of any question of legality. Attempts to do so only tend to becloud the issue and weaken the case for the medical groups. As an economic problem it would seem desirable and possible to solve this in a manner mutually satisfactory and without exploitation of anyone—physician, hospital, or patient—provided it is done at the local level, taking into account the varying conditions in different areas. This would require calm judgment and understanding, devoid of interference from outside circles, whether they represent hospital or medical groups. Surely a hospital would not be so shortsighted as to try to keep a desirable physician in an environment which was not conducive to good work. And no conscientious physician would seek a situation which would imperil the hospital. For both are interdependent.

In the delicate problems involved in human relations, progress is often the result of compromise. Compromise, if it is achieved without sacrifice of ideals, is extremely worth while and accomplishes much.

A recent example of the value of

compromise is the formation of the joint commission for approving hospitals, representing the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the Council of Medical Education and Hospitals of the American Medical Association. Much good will come out of that accomplishment, not all of which directly pertains to hospital standardization. It takes but little imagination to conceive of many examples of serendipity resulting from the cooperation of these representative groups. For after all most of our problems arise from lack of understanding.

For a long time I have felt that the greatest weakness of the hospital association was its failure to incorporate more staff physicians and trustees in its membership. All of us are vitally interested in this matter of providing the best possible care for the sick. Working together at both the state and national level, we would be able to accomplish much more than would be otherwise possible and we would thereby avoid many of these unfortunate situations owing to lack of understanding. Starting as it did as a society of hospital administrators, one can understand a natural disinclination to open the doors. Yet both trustees and staff physicians are constitutionally eligible and would add to the strength of the association. I feel strongly about this, as during my term as president of my state hospital association, I made this a major objective and, I'm sure, with beneficial results to the association.

By means of regular monthly letters to all personal members, as well as by individual contact whenever possible, it was urged that efforts be made to increase our membership in both the trustee and staff physician group. The response from a majority of the hospitals was very encouraging and we added a goodly number, both of trustees and physicians to our association. Six hospitals were able to report 100 per cent trustee membership. While the physician participation did not equal this, we did succeed in getting a considerable number, especially from among the leaders in the profession. Regional conferences were organized and meetings generally were held every two months at which the attendance by both trustees and physicians was very satisfactory. They took active part in the discussions, contributing a great deal of value.

As a result we developed a broader conception of our hospital problems which was beneficial to all. I did sense a certain apathy, although no open opposition to the idea, from some of the administrators but for the most part they went along loyally with the plan. Although efforts to continue their extension of membership have not been continued in any systematic manner the past few years, most of these trustees and physicians have kept up their membership and interest. We still see them at our state meetings, taking an active part in the proceedings. It has made for harmony in our organization and I only regret that more intensive efforts further to recruit these groups has not been made. One striking result of this move has been seen in the cooperation of the state hospital association and the state medical association in all matters of state legislation. Both groups have worked hand in hand, each realizing its interdependence, one on the other. Having been president of both organizations and realizing how closely allied they should be, I only hope this close relationship continues.

A broader conception of the hospital association and its objectives might have avoided many of our present difficulties.

WE GO TO EXTREMES

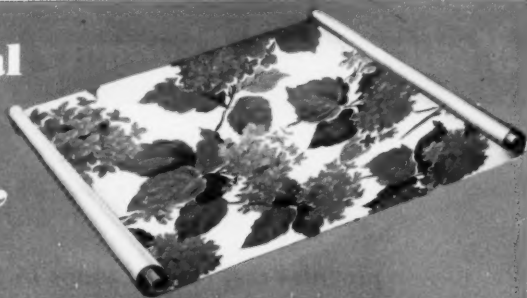
We have ever been a people given to going from one extreme to another in our social experiments. Examples are too numerous to need citing here. The pendulum swings widely in its arc and only after a period of time, does it come to rest at center. While in its arc we are often confused, bitter and antagonistic, torn by dispute and dissension; but, eventually, by mutual understanding, through compromise without sacrifices of ideals, the pendulum comes to rest and harmony prevails. History attests to the truth of this statement. So with our present problem, disturbing as it seems to be, we must have faith that the efforts of "men of good will" may succeed and that medicine and hospitals may continue cooperatively to achieve even greater things in the future.

¹Wilensky, C. F.: "Trends Influencing the Quality of Hospital Care—Hospitals and the Practice of Medicine." Presented at the convention of the American Hospital Association, St. Louis, September 1951.

²Cutler, R.: "Hospitals and the Practice of Medicine. From the Viewpoint of the Hospital Trustee." Presented at the convention of the American Hospital Association, St. Louis, September 1951.

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IMMOBILIZING LUNG CHAMBER

provides rest for the lungs in pulmonary tuberculosis

A. CHESMORE EASTLAKE JR., M.D.

Department of Medicine
College of Physicians and Surgeons
Columbia University
and Presbyterian Hospital
New York City

THE purpose of this paper is to describe the operation of the immobilizing lung chamber, which has been primarily used to provide rest for the lungs in chronic pulmonary tuberculosis. The report will consist of a description of the apparatus, the principle on which it is based and the actual technic of indoctrinating a patient in its use. Since the chamber requires intelligent and expert management, this outline was thought to be of value, not only to doctors but to technicians and nurses to whom the details of technic are naturally of interest.

The first report concerning the development and use of the immobilizing lung chamber by Barach appeared in 1940, following three years of experimentation with animals and human beings.¹ The original apparatus consisted of a small room containing a bed for the patient, with observations being made by two attendants standing alongside. Since 1940 additional studies

on the therapeutic value of the use of the chamber in chronic pulmonary tuberculosis have been published.^{2,3,4}

APPARATUS

The most recent apparatus consists of two sections, the ventilation mechanism and the chamber.

The ventilation mechanism (Fig. 1) consists of the following:

Piston. This has a diameter of 14 inches and operates in a vertical fashion on the top of the machine.

Motors. There are two motors, located in the box below the machine.

The total horsepower for ventilating and air conditioning the chamber is 2 h.p. The current supplied to the apparatus is 220 volts.

1. *Motor to drive piston* is the larger of the two, i.e. 1.5 h.p.

2. *Motor to operate the valve* regulates the cycle between positive and negative.

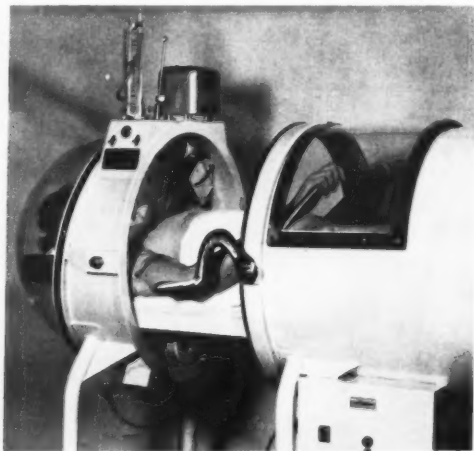
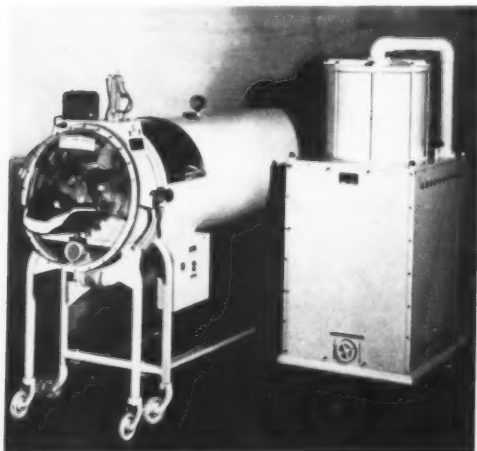
Handles. There are two handles, located on the outside of the box housing the motor, connecting rod and piston. One controls the total pressure administered to the patient; the other controls the cycles per minute.

1. *Pressure control valve*—By this means the pressure in the chamber may be varied from plus 40 mm. Hg. above atmospheric and minus 40 mm. Hg. below atmospheric, up to 70 mm. Hg. plus and minus.

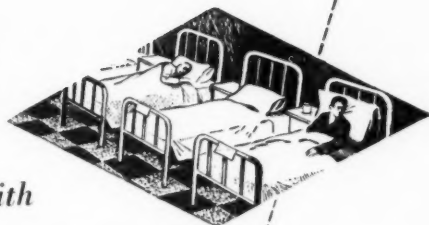
2. *Valve controlling cycles per minute*—This may be varied from 18 to 28 complete cycles per minute.

On one side of the box is a semi-flexible connection to the body portion

Left: Fig. 1. Chamber and ventilation mechanism of immobilizing lung chamber. Right: Fig. 2. Patient can open the chamber.



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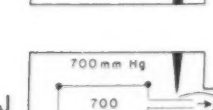
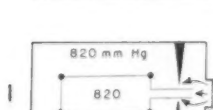
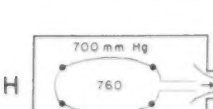
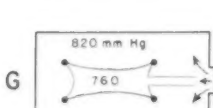
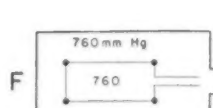
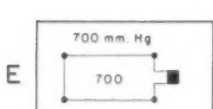
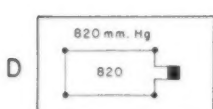
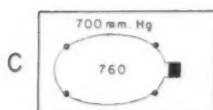
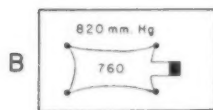
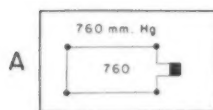


Fig. 3. Movement of walls of flexible container exposed to varying external and internal pressures.

Fig. 3a. Both the larger box and the container with flexible walls shown within are stabilized at atmospheric pressure (760 mm. Hg.)

Fig. 3b. When the pressure in the box is increased by 60 mm. Hg., the walls of the flexible container are compressed because it still contains the same number of molecules of air in decreased volume [equivalent to 760 mm. Hg.]

Fig. 3c. Conversely, lowering the pressure in the box by 60 mm. Hg. causes the walls of the container to expand.

Fig. 3d. If the pressure in the inner container is changed to equal the pressure in the box, the inner container retains its original shape, as in Fig. 3e.

Fig. 3e. The converse of Fig. 3d.

In the following diagrams the larger box will represent the immobilizing lung chamber with piston to raise and lower pressure therein, while the inner container represents the lungs and nose to alveoli air passageway.

THUNBERG CHAMBER

Fig. 3f. The piston is in the mid-position in the cylinder and the chamber and lungs are stabilized at atmospheric pressure.

Fig. 3g. If the pressure is rapidly raised in the chamber, the lungs are compressed because the increase strikes the outside of the lungs immediately while it is delayed in reaching the alveoli because of the relatively narrow air passageway. In a moment, however, were the piston to remain so placed, the lungs would re-expand to appear as in Fig. 3d.

Fig. 3h. The converse of Fig. 3g.

IMMOBILIZING LUNG CHAMBER

Fig. 3i. Increase in pressure in the chamber and outside of the lungs is delayed by the opening of the baffle or collar around the neck of the patient corresponding in relative size (and delay) to the opening of the air passageway to the lungs.

Fig. 3j. The converse of Fig. 3i.

of the chamber. This section weighs about 750 pounds.

The chamber consists of two parts, the shell for the patient's body and the head section with a total weight of 700 pounds.

Shell. This measures 24 inches in diameter, 48 inches high from the floor on a wheeled frame, and 60 inches long. It rests on a rectangular shaped frame containing four casters for ease of mobility and includes the following:

1. *Transparent plastic window*—On top of the shell, over the area of the patient's chest which is used to view the chest of the patient when he is in the machine.

2. *Aneroid gauge*—Also on top of the chamber, calibrated in millimeters of mercury, by which the total negative and positive pressure in the chamber is determined.

3. *Aperture*—Located near the gauge is an opening into the shell of the chamber, 2½ inches in diameter, controlled by a handle on the inside, by means of which the patient may release the pressure in the chamber while the motor is operating. He then may feel air rushing in and out of the chamber without a sensation of pressure.

4. *Handles*—These are located at the midpoint in the diameter of the shell at its connection to the head frame. There is one on each side which serves to fasten the head portion and body portion of the chamber together. These may be operated either from the inside or from the outside.

5. *Air conditioning*—Within the frame supporting the body portion of the chamber is the air conditioning apparatus which is air cooled. Older models contained a water cooled air conditioning apparatus.

Head Section. This is attached to the shell and measures a total of 18 inches in length and consists of the following:

1. *Dome*—A transparent hemispheric "bomber nose" measuring 24 inches in diameter.

2. *Frame*—This is attached to the dome and measures 6 inches long.

3. *Pan*—Into the dome and attached to the partition between the dome and the frame of the head part projects the pan, upon which a pillow is placed when the machine is in operation.

4. *Wheels*—An independent set of wheels is attached to the frame.

5. *Bed*—This extends down into the body shell portion of the chamber and

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contains a mattress which is attached to the head frame and on which the patient lies. A hair mattress is generally preferable to one composed of foam or sponge rubber, since a rubber mattress expands and contracts with the changes in pressure, making it difficult to determine whether the chest alone is moving (that is, the patient is not immobilized), or whether the entire body is moving up and down with the mattress. The foot end of the bed contains wheels which ride on the inside of the body shell portion, forming a four point suspension of the bed and allowing ease of opening (Fig. 2).

6. *Switches*—The frame contains off and on switches both inside and outside of the chamber.

7. *Light*—Located in the frame, to enable the patient to read, or for examination of the patient's chest, with switches inside and out.

8. *Two-way loud-speaker*—To enable the patient to communicate with the outside and through which the attendant may speak to the patient.

9. *Collar*—Between the transparent dome and the frame is a transparent partition through which there is an opening for the head. A vertically sliding collar attached to this partition is used partially to occlude the opening around the neck. This collar is also adjustable from either inside or outside of the chamber.

10. *Thermostat*—Located inside of the chamber, attached to the frame to allow the patient to air condition the environment to suit himself.

11. *Water manometer*—Found on top of the frame, it has one arm leading to the head portion of the chamber, and another arm leading to the body section.

It is obvious from the foregoing that the present chamber is designed to allow the patient to get into the chamber, turn on the motor and adjust his differential pressure without help from an attendant. This, indeed, the patient learns to do after the first few days of treatment.

The entire apparatus creates less noise than the average vacuum cleaner; however, its place in the hospital must be decided upon by a hospital staff. In the Columbia-Presbyterian Medical Center this chamber is in a private room with the patient's bed, enabling him to get into it at any time and avoiding the delay of waiting for the nurse or attendant to transport him to wherever it may otherwise be.

Table 1. Alternating Pressure and Cycling Rate of Immobilizing Lung Chamber for Alveolar Ventilation of 4000 cc. per Minute (Functional Residual Air of 2100 cc.—Anatomical Dead Space of 140 cc.)

Cycles per Minute	Total Pressure mm. Hg.	Tidal Air	Pulmonary Ventilation
20	123	340	6800
21	119	329	6920
22	116.5	322	7080
23	113.5	314	7220
24	111	306.5	7360
25	108.5	300	7500
26	106	293.5	7640
27	104	288	7780
28	102	283	7920
29	100	278	8050
30	98	273	8200
31	97	269	8340
32	96	265	8480
33	95	261	8620
34	94	258	8160

Pressure required at cycles from 20—34 per minute to achieve slightly higher than normal alveolar ventilation. This is used during training period. For patients with adequate pulmonary function, these pressures can be lowered 5—10 per cent, depending on degree of relaxation when patient has been trained.

PRINCIPLES

1. *During normal breathing*, Normally the intrapulmonary pressure and intratracheal pressure vary but slightly from the atmospheric. Increasing the number of molecules of oxygen in the lungs is therefore accomplished by increasing the volume of the lungs. Normal breathing is a constant pressure, changing volume mechanism.

2. *In the immobilizing lung chamber*, In the chamber the volume of the lungs does not vary. An increase in the number of oxygen molecules is accomplished by alteration of the pressure within the lungs. Chamber breathing, thus, is a constant volume, changing pressure respiration.

3. It follows from this that since the pressure in the lungs and outside the lungs is exactly the same, there can be no movement of the lungs, i.e. the lungs are completely at rest.

EXPLANATION OF PRINCIPLES

All of the air that is pumped into and sucked out of the chamber makes its entrance and exit in the head end of the chamber.

1. *Positive phase*, As the air strikes the nose of the patient and the pressure wave starts down into the lungs, the air also passes around the neck under the adjustable collar. In this way as the pressure wave gradually builds up in the lungs it also builds up over the external thorax to an equal degree. The size of the opening around the neck of the patient is adjusted to compensate exactly for the time required for the air pressure to build up in the lungs.

2. *Negative phase*, As this phase begins, air is withdrawn from the nose

and then from the lungs, and at the same time it is being withdrawn from the body portion of the chamber under the collar about the neck of the patient.

During any portion of either phase, therefore, the pressure within the lungs and within the body shell (surrounding the external thorax) is always the same.

As shown in the diagram on Page 108, a series of flexible walled containers may be used to demonstrate the principles of operation of the immobilizing lung chamber (Fig. 3). The lung may be compared to a container opened to the atmosphere and exposed to an alternating pressure of plus 55 and minus 55 mm. Hg. The function of the baffle is illustrated in these diagrams.

The total pressure for the cycles per minute required adequately to ventilate most individuals is indicated in Table 1. The total pressure is divided by two in actual operation, since half the pressure is above atmospheric and the other half is below. During the training period these pressures have been found satisfactory, but after the patient has learned to relax in the chamber the total pressures may be reduced 10 per cent, namely from 110 mm. Hg. to 100 mm. Hg., and the differential pressure from 5 cm. to 3.5 or 4 cm.

Air pressure in the positive phase builds up higher in the head end than in the body end because of the constriction accomplished by the collar. This is relatively equal to the constriction produced by the respiratory passageway between the nose and the alveoli. A momentary differential pressure, therefore, exists between the head

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section and the body section. This differential pressure is measured by the water manometer on top of the chamber. During the positive phase, a positive deflection occurs in the water manometer in the arm attached to the head end. During the negative phase of the chamber a negative deflection is observed in the same arm of the manometer. The differential pressure required to immobilize the majority of patients is 5 cm. of water positive and 5 cm. of water negative.

INDICATIONS

The immobilizing lung chamber is a unique device designed to achieve total arrest of lung movement. Its advantage over bed rest is evident, since in bed rest some degree of lung motion takes place.

Immobilizing lung chamber therapy has been employed in:

1. Advanced pulmonary tuberculosis in which no other therapeutic procedure was contemplated.
2. Cases with pulmonary cavity in which an alternative procedure was thoracoplasty.
3. Cases of pulmonary cavity which reappeared on termination of pneumothorax.

In our opinion, this therapy may be used in selected cases in preference to pneumothorax, thoracoplasty and pneumoperitoneum. Further experience is required to determine to what extent time may be saved by utilizing the chamber therapy in preference to bed rest in early cases. As a result of evidence provided by its use in more advanced cases, it would appear reasonable to suppose that a more rapid healing, both of exudative and cavitary tuberculosis, would take place with bilateral lung rest than with body rest which allows lung motion. In contrast to thoracoplasty or extrapleural plombage, the lung is healing in its future anatomical position, which is also different from the reexpansion which must occur in pneumothorax or pneumoperitoneum.

When a patient within the chamber is unable to achieve complete immobilization of the chest walls, the cause is excessive resistance somewhere in the airway between the pharynx and the alveoli. This may be produced by pulmonary fibrosis, bronchospasm, or pulmonary emphysema. Although the dyspnea of patients with pulmonary emphysema and bronchial asthma is relieved during residence in the immobilizing lung chamber, the degree

of bronchial resistance is such as to prevent an equal pressure from being maintained on the inner and outer surfaces of the chest wall, and, in that way, interferes with immobilization of the chest.

With these limitations, the use of the chamber is indicated, therefore, for any patient with pulmonary tuberculosis in whom it is thought that rest would be of value.

A NEW DEVICE

A modification of the immobilizing lung chamber in which an abrupt outlet of air at the peak of the positive pressure cycle is produced, with at the same time a differential pressure compressing the thorax and abdomen, has recently been employed to facilitate the elimination of bronchial secretions. This mechanism, which has been referred to as the mechanical cough chamber, may have certain uses in the treatment of pulmonary tuberculosis, especially in cases of blocked cavity. The modification consists of a 5 inch opening attached to the head end of the chamber which is suddenly released through a solenoid valve.

TRAINING PATIENT

Before the patient is introduced to the apparatus the chamber must be made ready and carefully checked. Before treatment is instituted the patient should be told what to expect. The following steps are suggested:

Prepare the Head Section. A pillow is placed in the head end of the chamber on the pan provided, and the mattress is covered with a sheet.

Check the Water Manometer. Water is placed in the water manometer to the zero level and the machine is turned on to be sure that the gauge over the body part of the chamber registers roughly plus and minus 55, or plus and minus 60, as desired. It is not necessary that the gauge register exactly plus and minus 55 or 60, but that the total swing of pressure is 110 or 120, since a mid-position of 0 (atmospheric) is employed to reduce peak amperage to a minimum. The positive phase begins when the needle leaves the minus 55 mark. The attendant can determine by the sound of the motor the beginning of each cycle. While watching the patient he can tell whether chest movement takes place in either the positive or negative phase.

The cycles of the chamber are counted to be certain that it is running

at 22, 28, or however many cycles per minute are desired. A complete cycle is from the plus 55 mark to minus 55 mark and return. Both the total pressure and cycles per minute may be altered by controls on the ventilation mechanism.

Orient the Patient

1. *Explain mechanism of the chamber.* The chamber is closed and the motors are turned on, allowing patient to hear the noise to which he will be exposed. He is shown that he can close and open the chamber from the inside unaided, so that he can get out at any time, reducing fear of being locked in. He is shown the thermostat, the friction blocks for self-adjustment of the collar, and, finally, the valve permitting the pressure to escape into the room.

2. *Describe anticipated sensations.* The patient is informed that he will experience a feeling in his ears, such as that experienced when ascending and descending rapidly in an elevator. Mention that this may be annoying for several hours, but that he will become oblivious to it. If the patient has any fullness in his ears after the treatment he may eliminate it by holding his nose and mouth and blowing until he feels a click in his ears. This mechanism will equalize the pressure on both sides of the eardrums and may be practiced as often as desired. When the patient has a cold he may also feel pressure in the sinuses. This may be largely relieved by use of a vasoconstrictor solution. No patient has been forced to discontinue treatment because of ear or sinus disturbance.

The patient is told that he may cough or talk while in the machine, because the pressure between the head and the body is approximately equal. In the Drinker type of respirator one cannot talk during the negative phase, since in this phase the differential pressure may be 15 to 25 cm. In the immobilizing lung chamber the difference between the head and body portion of the chamber is but a momentary 5 cm. of water; thus the patient is not forced to breathe in by the machine.

Introduce Treatment

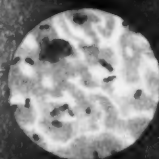
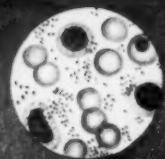
1. The patient is placed on the chamber bed with the shell open. The port to the outside (on top of the chamber) is opened preventing pressure from being built up. The patient then slides his head through the partition opening while the attendant talks to him through the connecting tele-

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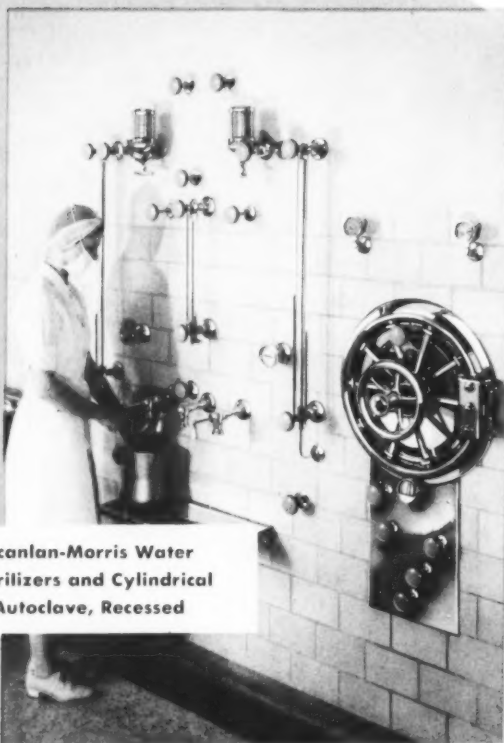
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phone to indicate that he will be in communication with the outside.

2. The motor is then turned on, allowing the patient to feel the rush of air and noise of the chamber without pressure change in his ears.

3. The chamber is then closed. Since the port is controlled from the inside, the patient is instructed through the connecting telephone to close the port slowly, realizing that there will be a slight increase in noise until it is closed and that a pressure may be felt on the ears during this time. Throughout this procedure the attendant talks quietly to the patient with a reassuring manner.

4. The patient is now instructed to grasp the sliding collar around his neck and pull it down while watching the water manometer. As the collar is lowered more and more, a differential pressure will be seen in the manometer, beginning with 1 cm. of water negative pressure and 1 cm. of water positive pressure, depending upon the phase of the chamber. The differential pressure is initially set at 5 cm. of water. If the pressure goes to 5 cm. on one side and 7 cm. on the other, for example, there is usually something in the opening which is not constant in both phases. Should there be anything loose about the neck, such as a portion of the patient's shirt or a corner of the pillowcase, the opening might be more obstructed in one phase than in the other. In this case, air would enter from the head to the body section at one differential pressure and leave from the body to the head section at a different pressure, since the size of the opening changes. Immobilization is best obtained when the opening around the neck is constant and, therefore, the pressures viewed in the water manometer are equal in both the positive and negative phase.

ADAPTATION TO IMMOBILIZATION

The learning process may take as long as three days in a patient who is exceptionally nervous, or in one who has claustrophobia. In other patients the entire procedure outlined may take but 15 minutes.

When the patient is comfortable, with the water manometer set at 5 cm. pressure differential, his chest is observed. If marked motion is seen, more than is present with normal respiration, and nervousness is ruled out, the patient may have an obstruction to the free passage of air in and out of the alveoli. Further trial then is probably

useless, since the patient may be suffering from advanced emphysema or fibrosis. However, if the chest moves no more than was seen during normal respiration, the patient is told to breathe *with* the machine. This is done by asking him to watch the water manometer. When the pressure phase is indicated, i.e. when the side of the water manometer connected to the head end is depressed as air is rushing into the head end, he is told to inhale, and when the negative pressure is indicated, he is told to exhale quietly. After a few cycles of breathing he is told through the telephone to inhale and exhale less and less, and then stop breathing after a *normal quiet expiration*. This is the position of the chest to be assumed during immobilization.

The attendant may have to explain to the patient that he must lie in the machine with his glottis open and his diaphragm relaxed. In other words, he must *not* hold his breath. If he strains to hold his breath he cannot be immobilized and chest movement will result. This is illustrated in the diagram of the closed balloon. In a few cases the chest becomes quiet immediately, and the patient may not breathe again while in the chamber. In the average case, however, the patient needs supervision of one hour daily for four or five days, or occasionally longer, before he becomes relaxed enough to let the machine breathe for him. The chemical requirements for oxygen and elimination of carbon dioxide are satisfied, but patients must be taught to relax; they sometimes have to be convinced that the machine is able to breathe for them.

When the patient has been well trained it is possible for him to be immobilized with a pressure of 4 cm. of water, or on rare occasions 3 cm. Some patients, however, need more than 5 cm. of water. A patient who requires 8 cm. or more pressure to counterbalance the excessive resistance of his airway is generally not suitable.

The water manometer pressure required is determined as follows: Watch the patient and the alternating pressure and learn the phase of the chamber by the sound. If the chest expands slightly during the positive phase (and, thus, compresses during the negative phase), air is entering the lungs more rapidly than around the outside of the chest; less than 5 cm. of water is then needed and the opening around the neck is enlarged. If the converse is observed, compression

of the chest during the positive phase (and expansion of the chest during the negative phase), then air pressure is exerted on the outside of the lungs too fast; the collar is then lowered so that an increased pressure is seen in the water manometer.

The rate of cycling and the pressure may be adjusted separately. If the patient seems to require a breath every so often, then the rate or the pressure, or both, may be increased. When the pressure ventilation is stopped, i.e. the motor turned off, patients generally resume spontaneous breathing slowly. If there is no breathing for five or 10 seconds, which is rare, he may be considered hyperventilated; the pressure or the rate is then decreased. In any case, the chest should be motionless during treatment to ensure maximum therapeutic benefit.

When the training period is completed and the patient is considered immobilized, the surface of the abdomen may be observed to move with the cycling of the machine. This is caused by gas in the intestines which is compressed and expanded during each complete cycle. Although there is compression of gas in the abdomen during the positive phase the diaphragm should not move, since the pressure transmitted downward on the diaphragm from the lungs is equal to the pressure being transferred upward.

THE PATIENT'S CLOTHING

The clothes that the patient wears while in the chamber and the articles he takes into the chamber with him are of considerable importance. For the first few days in the chamber, when his chest is being observed by the physician, the patient should wear nothing over the upper half of his body. After the training period is ended, he may wear a shirt with a tight-fitting collar, preferably a crew-neck sort of sweater, so that there will be no material to flap in the opening. A hairnet must be worn by the patient with long hair, and it must be securely fastened to the head. Socks may be worn if the patient's feet become cold.

The patient should be told not to have anything loose in the head end of the chamber, such as a hairnet, a tissue, or candy, because these may blow about and lodge in the air duct from the piston to the chamber. The nose may be blown or sputum may be coughed into a tissue merely by rais-



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ing the collar, but the tissue should be put in a box.

LENGTH OF TREATMENT

There has been no evidence of harm from the utilization of the chamber in 30 patients who have had either four to seven months of continuous use, or in patients who have had two courses of four months each, or in one patient who had three courses of four months each. There would, therefore, appear to be no reason to warn against its use on the ground of conceivable injurious effects.

The minimum period of treatment each day should be nine consecutive hours (except for meals). This would allow an institution to treat two patients per day in each chamber. It is preferable, however, to allow the patient from 10 to 12 hours in the chamber each day. Residence in the chamber is increased one-half hour per day for the first six days and then at a rate not greater than one hour per day, because the patient's back, usually unaccustomed to the supine position, may become tired.

The average length of treatment is

four to five months, and probably should not be extended beyond six months without a rest from the chamber for a period of time, after which a second course may be instituted. Upon completion of treatment the patient is placed at postural bed rest, six to seven hours daily, for a period of two to three months, to make certain his disease is arrested. After this period he is placed on a regimen of gradually increasing activity, as would follow any other form of tuberculosis therapy leading to an arrest of the disease.

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The majority of patients do not complain of boredom. When a patient is well trained, radio earphones or a loud-speaker may be placed in the head end of the chamber if the patient wishes to listen to the radio. The radio is placed outside of the chamber and a wire is passed through a prepared opening. The patient may read a magazine or book and may lie on one side or the other to some degree, but he should be able to watch the water manometer.

Patients have been observed for hours manifesting few or no muscular movements which are strikingly different from their behavior on bed rest. They rarely turn from side to side or move their arms and legs.

The desire to smoke disappears, even in patients who previously were confirmed cigaret smokers. However, when the patient takes three or four normal breaths after removal from the chamber, the impulse to smoke returns. This is but one of the signs of the unusual degree of mental as well as physical relaxation that occurs during ventilation without chest movement or voluntary respiration.

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REHABILITATION UNIT

(Continued From Page 70)

nonofficial. How intimate, for example, are the hospital's contacts with the state vocational rehabilitation agency and to what extent are its services being used—services that will not cost the hospital one cent? How close are its contacts with the local societies for crippled children, the National Foundation for Infantile Paralysis chapter, the various welfare agencies? Often the reason the separate efforts of such groups seem ineffective is the lack of a functional focus—something very different from "coordinating" schemes on paper.

Insofar as it is a measure of anticipated activity, the problem of space is closely allied to the problem of personnel. It differs in one important respect, however, and that is the primary consideration of location. We can all remember when it was the rule to tuck the physical and occupational therapy departments away in the basement or utility areas like a stepchild. Whether or not the area was well lighted and airy or whether, in fact, it had any windows at all was not regarded as important.

HASTENS PATIENT'S RECOVERY

As a recognized specialty, physical medicine and rehabilitation should be on a footing with all other departments. Since it is the link between the hospital and the return of the patient to the productive life of the community, the brightness and cheeriness of the surroundings have an important bearing on the process of rebuilding morale, of instilling the motivation for a return of that movement which constitutes life.

For smaller hospitals with average outpatient departments, the American Physical Therapy Association² (speaking for physical therapy alone) suggests the following schedule: for a 50 bed hospital, 10.56 square feet per bed; for a 100 bed hospital, 8.64 square feet per bed, and for a 200 bed hospital, 7.20 square feet per bed.

In estimating the amount of space for physical medicine and rehabilitation at the University of Illinois Research and Educational Hospitals, we

made studies of comparable institutions with established departments of physical medicine and rehabilitation. Although physical space could not be allocated according to the minimal number of patient referrals from both clinics and hospital wards at the time the department was organized, proximity to wards and outpatient clinics and a location permitting future expansions were considered of first importance. The allocated area was planned for balanced operational relationship to administrative offices and diagnostic and treatment sections. It now consists of 482.4 square feet for administrative offices and 3958.5 square feet for diagnosis and treatment. At present, an inpatient service is being planned to complete a 24 hour physical medicine and rehabilitation service. The department was established primarily to provide research and teaching facilities, treatment service being considered secondary.

If it is necessary to remodel a given area in a hospital to establish a department, it is important to consider the aforementioned items, as well as the specific departmental objective according to the type of hospital.

In the division of space, certain of the treatment cubicles may be walled for privacy, while others may be curtained for adaptability, i.e. combining spaces for gait training, and so forth. This facilitates the effective use of all space, which is particularly important where the total area is restricted. For certain examinations and tests, however, there should be at least one completely private room available.

At the University of Illinois Research and Educational Hospitals, we have a large separate room for therapeutic exercise including step and curb climbing, progressive heavy resistance, diagnostic table, including ergograph, and multiple units of equipment for progressive resistance exercises of a given muscle group, walking bars, and all those activities relating largely to locomotion. If at all possible, the department should provide such a room; if not, areas should be combined at certain times to create sufficient area

for such activities. Also the hydrotherapy area should be separated from the other treatment areas because of noise and high humidity, and preferably should be air conditioned to maintain constant dry and wet bulb temperatures.

The usual toilet facilities found in hospitals for outpatients are not adequate for use by patients being treated in departments of physical medicine and rehabilitation. In the first place, toilet facilities should be located conveniently near the treatment section or where the largest group of patients is being handled. In this way, they may be used routinely as well as for rehabilitation training purposes. Special equipment must be provided, such as handrails on both right and left for patients getting up and down from the stool; and the entrance to the stool should be of a width adequate to permit entrance of a wheel chair. The lavatory should also be of sufficient height to permit the arms of a wheel chair to go under it. The toilet facilities are just one of the many items that should be considered when a department is being planned which can be used for other patients as well as departmental personnel.

STORAGE SPACE IMPORTANT

Because certain equipment, whether for treatment or research, is not always in use, storage space is very important. It is hardly necessary to add that administrative space should be partitioned off from treatment space, and that there must be space for patients to wait. The therapists' dressing room should have, in addition to the usual toilet facilities, a shower and adequate lockers for storing uniforms (minimal inside dimensions 71 inches high, 18 inches wide and 20 inches deep).

The manual² "Essentials of a Good Physical Therapy Department" contains suggestions regarding lighting, wiring, plumbing, flooring, and decorating generally applicable to physical medicine and rehabilitation departments and need not be enumerated here. However, we have found the use of color throughout the department for floor and wall coverings, equipment, including crutches, to have definite psychological advantages. From the same source² may be obtained lists of required equipment and the amount needed for 50, 100, 200 and 500 bed hospitals.

In larger teaching and research institutions, of course, considerable

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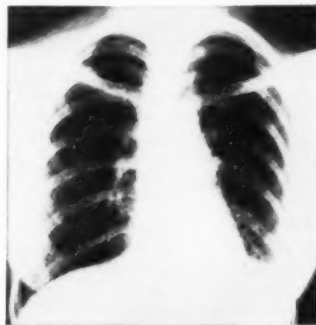
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equipment for studies in electromyography, kinesiology, and other special investigation will be needed, and adequate space must be provided for its use.

Much of the basic equipment, such as steps (adjustable for all types of patients as well as for the smallest child to the tallest adult), walking bars and shoulder wheel can be built by the hospital maintenance staff. Of other items, only one is needed for departments in hospitals up to 500 beds; for example, progressive resistance exercise apparatus, stall bars, head sling for cervical traction, triple posture mirror, and so on.

Wall mirrors at least 6 feet in height and 2 feet in width should be placed in the therapeutic exercise room wherever there is available space, the lower border flush with the floor. It is not possible to have too many mirrors and most departments have too few. It is important to have a mirror at either end of the parallel bars used for ambulation training or any other area where patients are being trained in ambulation techniques, with or without crutches.

For hydrotherapy, most general hospitals will find the Hubbard tank, because of its modest size and therapeutic control, best adapted to their needs. Pools, or combination Hubbard tank and pool, of course, are usually a standard item for hospitals specializing in poliomyelitis and other neuromuscular disabilities, where a full exercise range is a component of a long-term program of care.

It goes without saying that purchases of equipment should be confined to items approved by the Council on Physical Medicine and Rehabilitation of the American Medical Association. By writing the council, a list of accepted apparatus and manufacturers can be obtained without cost.

Once the department is organized, housed and equipped, the twin questions of administration and finance emerge. In addition to the general administrative problems familiar to medical and hospital personnel, certain others crop up peculiar to the specialty. One of these, certainly, relates to the desirability of keeping a running record of the service given by the department as reflected by use of personnel and facilities. This problem begins with the referral of the patient and follows through to dismissal.

The recording system should be so devised that, while accurately and cur-

rently up to date, it will not place an administrative burden on the personnel. Our own system begins with a form entitled "Physical Medicine and Rehabilitation Consultation or Request and Record." It provides identification space, including the source of referral and whether or not the treatment is to be given in the department or on the ward.

The next two spaces provide for the referring physician's diagnosis for which treatment is requested and the results desired. The latter is signed by the physician. Next is a summary of the physiatrist's findings and a signed summary of the treatment prescribed. At the bottom of the first page is a blank calendar on which treatments are recorded by the physical therapist or occupational therapist, the former signing in one channel and the latter in another so that the general category of treatment can be easily identified.

Each day the clerk totals the treatments on a special tally sheet, and these can in turn be totaled for the week, month and year. These totals show hospital or clinic patients according to the source of referral, whether they are new patients, patients under treatment, patients dismissed, and whether or not these treatments required visits to the wards. A copy of procedures for both inpatients and outpatients can be obtained by writing to me.

PHYSICIANS MUST UNDERSTAND

In the matter of referrals, it may be relevant to point out that although there is increasing awareness of the potentialities of physical medicine and rehabilitation in speeding recovery, many physicians are still not acquainted with the results possible through these procedures. Elkins⁵ recently pointed out that these attitudes are the result of inadequacies in the basic education of physicians. While we can look forward to improvement in this situation with the development of undergraduate and postgraduate curriculums, it should be remembered that the department can, through tact, diplomacy and industry, interest the general professional staff in what such a department has to offer, particularly since this work has, in addition to scientific interest, great human appeal.

An item not to be ignored in any discussion of administration is that of finance. It is, of course, impossible to make any specific suggestion regarding fee schedules for specific procedures or combinations of procedures, since these



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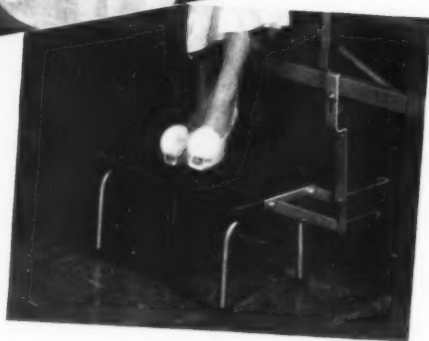
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Furniture for the Modern Hospital

involve general policy of the institution as a whole and vary according to the conditions of the community. Time required for the treatment is a good relative guide within the framework of this established policy.

In this connection, one suggestion is particularly pertinent—the basic philosophy of rehabilitation is applicable in the problem of fixing fee schedules, and by applying it rigorously the chances of confusion and inconsistency will be greatly minimized. The philosophy of rehabilitation is *integrative*; that is to say, a complex of services must be brought to focus on the individual, and the fees charged should be in terms of this focus, not its component parts. Instead of itemized fees for separate steps in the total rehabilitation process (one charge for physical therapy, another for occupational therapy, another for speech therapy, social service, and so on) a single fee should reflect the totality of the process.

This question of finance cannot be discussed without referring again to the agencies, official and nonofficial, operating within the community. When there is an actual, operating, direct service, such as physical medicine and rehabilitation, providing what I have previously referred to as a "functional focus," much of the problem of coordination of effort, which we hear a great deal about, disappears. The many services needed by the individual for physical and vocational adjustment, converging in one place, reach their maximum of effectiveness. These organizations can well furnish a substantial source of revenue and, by furnishing a common point of interest for these diversified groups, strengthen the community position of the entire hospital. It is, in other words, a public relations project as well as an administrative problem.

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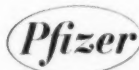
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Tile and Metal Keep the Kitchen Spotless

MAJ. BERT MERRILL

Waco, Tex.

MAXIMUM efficiency in meeting a huge food service load has been developed in the new kitchen of Providence Hospital, Waco, Tex.

Conveniently located at the ground level on the first floor of a new wing containing 125 beds, the new kitchen replaces a former second floor food preparation area in the original building, and is set up to provide food service for 275 bed patients and approximately 180 hospital employees. It emphasizes the last word in sanitation and ease of maintenance, while tackling a food preparation load more than three times that of the former department.

Designed in rectangular form, with separate departments radiating off the U-shaped tray preparation center, the kitchen is done throughout in tile and stainless metal. The first in central Texas to make 100 per cent use of the gleaming material, the Providence Hospital dietary department, headed

by Mrs. A. Jordan, specified it wherever metal is used throughout the kitchen, and the result is its employment in many fixtures where normally wood, linoleum or tile surfaces might have been used.

The ability to make a quick inspection of the operation of all departments was made a key point in the design of the kitchen, according to Mrs. Jordan. Accordingly, each department radiates off the "focal point" where a crew of six girls around the U-shaped table makes up food trays which are transported in seven electrically heated carts to five floors in the new annex, and two in the original building. The tray unit and heavy-duty cooking area occupy approximately 40 per cent of the entire kitchen space, separated from the partitioned departments on the right wall

by a wide corridor, extending the entire length.

Each department along the corridor is separated by a 5 foot tile wall, over which it is possible to inspect or keep a check on progress. First on the right is the dishwashing room, with complete automatic glasswasher, dishwasher, prewashing equipment, and stainless metal storage racks for utensils. Next is the diet kitchen, and in the center, looking directly into the cooking area, is the glassed-in, air-conditioned office. Immediately opposite, and arranged to face the end of the grill and range, is a partitioned-off pot and pan sink.

More separated departments, all appearing one after another down the hall, include a vegetable preparation unit located on one side of a huge refrigerator, which also opens into the meat preparation department on the opposite side. The large tile refrigerator, serviced by a single unit, incidentally, is unique in that it is divided into four sections, each opening into the appropriate department. Included are a 6 by 8 foot dairy refrigerator, 6 by 8 foot produce refrigerator, 12 by 8 foot meat box, and a 4 by 6 foot deep-freeze unit, operating at -10° F. Overhead dome coolers, powered by a single 3 h.p. condensing unit, provide needed cold for each of the sections.

At the extreme end of the corridor is a convenient truck dock entrance, from which foods can be wheeled directly into the storeroom, and here the corridor angles off sharply to the left, giving access to the garbage re-



The tray preparation area is the focal point of the department. A crew of six girls, working at the U-shaped table, prepares trays for distribution throughout the building on heated carts.



Mercy Hospital, Dyer, Indiana

FOR

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THAT PLEASES . . .

In nearly seven decades of specialized service to those who serve many people each day, we have learned much about blending teas that please. The country's leading hospitals serve Sherman Blend exquisite tea to cheer the sick and stimulate the convalescent appetite. Clubs, hotels, restaurants know that this luxury beverage at an economy price will flatter the taste of the most fastidious patron. For less than three-tenths of a cent per cup more, you can have this insurance of guest satisfaction.

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JOHN SEXTON & CO., CHICAGO, 1952



Looking down the corridor off which all sections of the kitchen branch.

frigerator in which all food refuse is held at 25° F. until it is hauled away.

The electric cart parking area, tray filling unit, chef's refrigerator, and heavy cooking grills, oven and hot tops, as has been pointed out, occupy 40 per cent of the space. Also departmentalized off from the corridor, on the left side of the kitchen, are the separate "soup kitchen" which incorporates steam kettles and a steam chef for all vegetable preparation, and the bakery, which is of equal size and is separated by a 5 foot tile partition.

"We attempted to follow an assembly-line procedure in branching each department off a single corridor in this way," a hospital executive stated. "The partitions provide a certain amount of privacy for each department, yet do not interfere in any way with transmission of verbal messages, or with visual inspection."

Incidentally, each of the separated departments is provided with its own stainless metal pot and pan sink, which takes a substantial load off the dishwashing and pot and pan rooms. Much of the clatter and din normally associated with washing of metal utensils has been eliminated in this way.

In addition to some 1100 meals served per day throughout the institution, the new kitchen provides hot foods for the steam table in an employees' grill, located a few steps away on the first floor of the hospital, plus a physicians' dining room, across the hall. The employees' grill, much patronized by visitors, ambulatory patients, and so on, includes a short-order grill, in addition to the steam table for

preparation of hot sandwiches, breakfast and special orders.

The kitchen is remarkable throughout for its extreme simplicity. Grease-proof coral-toned tile blocks make up the floor, while walls on all sides are tiled to within 2 feet of the ceiling with a buff ceramic tile carried through in all walls, partitions, and vertical surfaces. A high gloss aquamarine blue enamel is utilized for the upper 2 feet of wall past the 7½ foot extent of the tile, and over the ceiling. In combination with the stainless metal fixtures, this means that all surfaces throughout the kitchen are impervious to damage from water, according to Mrs. Jordan.

The kitchen employs an average of 24 regular employees, in addition to college students and local housewives who fill in on shifts. Both dumb-waiter service to the upper floors and the electrically heated carts distribute the foods. Only a small hot plate is installed on every floor for special heating; otherwise the electrically heated carts are more than adequate to maintain food at its best temperature.

The simplicity of the kitchen has naturally led to equal simplification of the sanitation program. It calls for a complete washing down of the tile walls once a week with ordinary soap and water, scrubbing of the tile floor twice a day with a special bactericidal detergent, and wiping down with wet cloths of all stainless metal surfaces an average of five to six times per day. A popular granulated soap is used for what small amounts of

grease have accumulated on the wall in back of the range and grill, or elsewhere. Because of the fact that huge volumes of water can be used without damage of any sort, the kitchen can be kept immaculately clean with less than one-third the effort formerly required, the Providence management emphasized.

FOOD FOR THOUGHT

Milk in Many Forms

With all the current excitement over this or that milk product—including yogurt, cultured or "plain" buttermilk, kefir and so on—it may be salutary to have the following definitions of popular fermented milks, released by the authoritative *Dairy Council Digest*.

Various microorganisms, when introduced into milk, convert the milk sugar into lactic acid and bring about changes in flavor (it is as simple as that!), such as in the following:

Buttermilk: A fermented milk which is the by-product of churning sour cream into butter.

Sweet Cream Buttermilk: Much different from standard buttermilk. It is the by-product of churning sweet cream for sweet cream butter.

Cultured Buttermilk: A fermented skim milk in which lactic acid producing organisms are used as a culture. Addition of a small amount of cream or butter after fermentation makes it closely resemble true buttermilk.

Acidophilus Milk: A sweet skim milk cultured with *Lactobacillus acidophilus*. About 5 per cent of either lactose (milk sugar) or dextrin (corn sugar) is usually added after fermentation and cooling.

Kefir: Whole, partially skimmed or skim milk into which kefir grains are introduced as a culture. The carbon dioxide developed during fermentation is trapped by putting the milk into tightly stoppered bottles during last stages of fermentation.

Bulgarian Cultured Milk: Much like acidophilus except that a different *Lactobacillus* is used for the fermentation and lactose or dextrin are not added.

Yogurt: Varies from other fermented milks in consistency and concentration of milk solids. A semisolid custard-like food with fine smooth texture. Made from concentrated whole milk, fermented with three kinds of bacteria.

THE READING HOSPITAL

Reading, Pennsylvania

E. ATWOOD JACOBS
Administrator

Dear Sir:

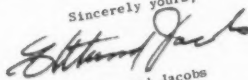
Responding to your inquiry about Mealpack, a pilot installation was installed and thirty private obstetrical patients were served for a period of five weeks.

The reaction of patients, physicians, nurses and dietary staff was wholly satisfactory and the results of this trial run convinced us that Mealpack is the only satisfactory method of inaugurating central tray service. Previous experience revealed that neither system met the needs of patients. With the decentralized system and its dual handling the food lost its palatability. Delays in serving in a central system resulted in patients receiving cold food. All of our experiments and investigation in the field convinced us that Mealpack permits the serving of hot, palatable food to patients with greater efficiency than any food service system that has come to our attention. Furthermore, it offers economies that are otherwise unattainable.

Plans are now being consummated to install Mealpack in the entire hospital and we will ultimately serve 450 patients.

I regret that time does not permit me to discuss all of the advantages of Mealpack, but if you should be in this vicinity do not hesitate to visit us and we will show you Mealpack in operation.

Sincerely yours,



E. Atwood Jacobs
Administrator

EAJ:nm

MEMBER OF COMMUNITY CHART

EVERY HOSPITAL WITH A FOOD SERVICE PROBLEM

will find real food for thought in the above letter. Written by an outstanding Administrator, it answers many hospitals interested in Reading Hospital's reasons for converting its buildings (450 beds) to MEALPACK service for all patients.

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Dietitian Jeanne Voltz pre-heats Mealpack Containers' inner Pyrex dishes in Mealpack Dish Heater. After this simple routine, hot meats, vegetables, rolls, etc., are vacuum-sealed in insulated Mealpack Containers, ready for tray set-up at main kitchen and for flexible distribution via Mealpack Tray Carts.



Student nurse Shirley Westman adds soup, hot beverage and ice cream to one of the 20 trays carried on each trip of Mealpack's Tray Cart. Each Cart rolls from main kitchen direct to floor serving areas. Literally a "portable floor pantry." Delayed trays may be served up to 2 hours after provisioning!



Delicious, selective menus for every patient—hot foods HOT and cold foods COLD. And Mealpack enables you to make very substantial cuts in food service costs.

Maintaining and keeping records on

KITCHEN EQUIPMENT

CHRISTINE RICKER

Director of Food Service
Stanford University

THE tools of the institutional kitchen have become increasingly precious in these days of priorities and scarcities. We have lived through a period of this kind before and we learned a great deal. Certain large institutions, such as government hospitals and telephone company cafeterias, have always had adequate maintenance records and programs of repairs. The small institution, too, will be wise to look over its equipment, see how it is being used, and devise, if it does not have them, a simple set of records.

This program naturally falls into four parts: (1) purchase and location of equipment; (2) permanent equipment records; (3) servicing control records weekly, monthly and yearly; (4) employee training regarding care of equipment.

PURCHASE OF EQUIPMENT

First of all, I am assuming that we have a chance to decide on the kind of equipment we want and the location in which it is to be placed. Sometimes this isn't the case, but if it is, let's know as much as possible about the equipment we own. If we expect to purchase any equipment, we must study the relative merits of one make over another. We want to know how easy the equipment will be to clean, to keep in order, and, above all, whether it will meet our needs.

Then we should think about the location of the equipment. If it is to be in the kitchen it will be placed so as to permit ease in cleaning and so as to be out of the direct line of bus-wagon traffic.

Since our imaginary situation is perfect (that shows it is imaginary), we

complete our research, decide on the equipment, and place the order. Here we assume that the storekeeper or office has a copy of the order in detail and is ready to receive it when it arrives. Let's hope it won't again be as it was during World War II when we placed orders for china and waited two years or more for them to be delivered.

WATCH AND ASK QUESTIONS

The great day comes and the equipment arrives. Let's take a mixer as an easy example. It will probably be crated and there will be envelopes attached giving detailed instructions as to its proper installation. When only one piece of equipment is being added to an existing building it is wise for the dietitian to watch the proceedings and ask questions. In a completely equipped new kitchen this may not be possible, but often she can study one piece at a time.

Well, our machine is installed and we are ready to take its life history. On the large equipment record we enter the serial number, motor number, the kind and number of attachments and, of course, if the bill is available, the date of purchase, vendor, and price. Also, it is wise to note the type of grease needed and any other special suggestions for its care. This record may be a card, a sheet from a loose-leaf notebook, or any form preferred. The form may be printed, mimeographed or typed, depending on the situation. The important thing is to have some kind of record.

Sometimes these forms are kept together with the parts catalog (which should have arrived with the machine)

and merely filed. However, I believe a separate book or card file is better. If the institution stamps a number on each piece of equipment this number should, of course, appear on the record. When the machine is ready, a service checking card should be posted.

If these cards are in a cellophane container they will be protected from dirt but, of course, not quite so accessible. The card should show the items to be checked, e.g. grease cups, crank case, motor. There also appear a date line and a place for the workman doing the job to initial it. There are always two kinds of maintenance; the need for this must be determined by the service department.

The machine may need weekly grease in one area and a special overhaul twice a year. These special overhauls should be determined in relation to an over-all program.

If a part breaks, we turn to our catalog and order the broken part by number. When this part is received we enter the date, cost and repair charge in the proper place on our large equipment record.

Perhaps we cannot "maintain" china, glass and silver, but at least we can keep records. For this we use a card file as we do for food supplies and any item is requisitioned just as is food.

Breakage and loss are always problems. We post price lists of all equipment and sometimes head it by "Let's put our money into food, not dishes." Mr. Wenzel, the food service consultant, suggests a picture of perhaps a plate, cup and saucer, and the price of each with the caption, "This breakage represents the profit on customers."

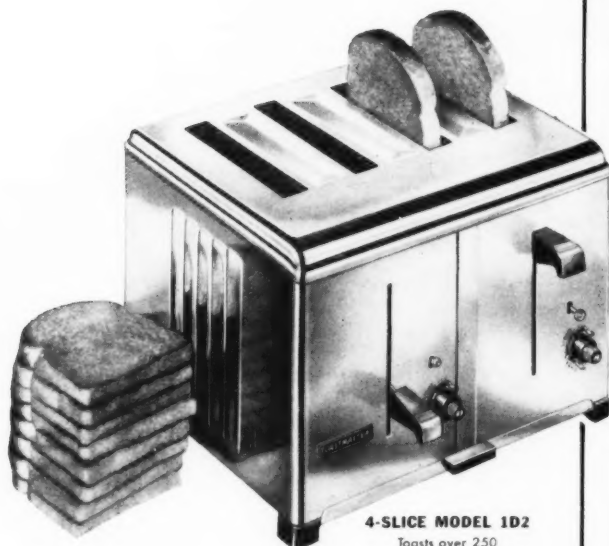
INCLUDE ON JOB SHEET

This is, of course, only part of our record keeping. We have established the arrival of the equipment, the vendor, seller's recommendations and our own formula for the maintenance. But how about daily care and daily checking? This may be taught by oral instruction (not a good idea), or incorporated in the job instruction sheets given any new worker.

It is hard to glamourize pot washing, garbage can scrubbing, and such menial jobs, but if a man is indoctrinated in the first place with the idea of the importance of his job he will treat the equipment with more respect.

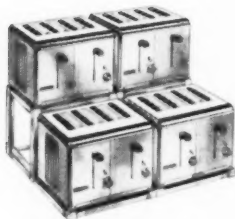
If the pot washer is responsible for the cleaning of a particular mixer, included with his outline of duties might be something like this: "Care of

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toaster for every need!*



4-SLICE MODEL 1D2

Toasts over 250
slices per hour.



A Toaster for every Hospital Need!

FOR THE MAIN KITCHEN... The 16-slice, Model 4-1D2-D (above), is ideal for larger hospital main kitchens. That's because it has plenty of toasting capacity—pops up over 1000 slices per hour!

FOR THE DIET KITCHEN... The 2-slice, Model 1BB4 (above), is perfect for diet kitchens. It pops up over 125 slices of toast per hour. Equipped with cord to plug into any wall outlet.

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HERE'S SOLID CONSTRUCTION, rugged dependability to meet the demands of heavy-duty institutional use. Its extra-thick chromium-plated finish is long-lasting and easy to keep sparkling bright.

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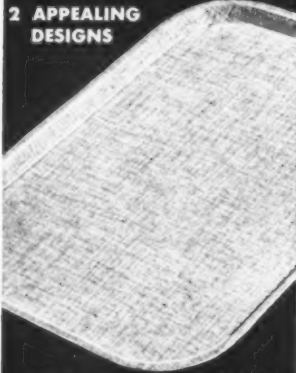
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Silite also offers you a complete line of standard "Tu-Tone" trays, a great value!



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Mixer: Wash and dry all used beaters, whips and bowls and put in proper place. Try not to hit on edge of sink, and avoid dents. Wipe off main body of mixer, avoid chipping enamel. Report any grease dripping. Any number of details might be added.

This is a brief illustration of how records can function in the case of one piece of machinery. It can, of course, be expanded to cover all equipment.

RULES FOR GENERAL CARE

Now to go to general care of all equipment. First and foremost, on all our job descriptions we have for each employee a few simple rules as to his cleaning duties. For example, in the case of a dish machine man, in addition to having a card posted showing the times of oiling and greasing the machine by the mechanic, we also need a direction card for operating instructions.

In the job instruction sheets we probably have more information as to the care of equipment. We may say, after general stacking, scraping and washing instructions, which should include a water temperature reading at the end of each meal: (1) Flush out machine; (2) clean strainer pans and leave out to dry; (3) clean rinse nozzles; (4) take curtains out to dry; (5) be sure top of machine is clean and empty.

Up to this point I have tried to suggest how we can maintain our equipment and can keep track of it from the moment we plan for its purchase until it is retired at a decent old age. Perhaps it falls to pieces. Or it may be overtaken by obsolescence or, as often is the case, our needs change.

We have found that in transferring such a piece of machinery from one place to another it is a help to have its complete "pedigree" in the equipment book.

There is always the routine care of equipment. We have used the dish washer and the mixer as two specific illustrations. For other major equipment we should follow these general rules.

Mechanical Refrigeration: (1) Open doors as little as possible; (2) close doors on walk-in boxes when working inside (make women employees slip on an extra smock or coat); (3) if refrigerators do not defrost on a cycle, check with an expert and find out how often you should defrost; (4)

replace door gaskets when they are needed.

Soda Fountain Equipment: Most of the upkeep comes in the routine daily cleaning but let us remember the ice cream cabinet. It is better to defrost by careful scraping with an ice cream spade than by pouring in hot water. The latter practice may cause trouble, e.g. the expansion of the refrigerant may cause the seal in the compressor to break. The carbonator should be on the list of equipment calling for a monthly checkup.

Gas and Electric Ranges or Ovens: (1) Clean grill tops daily with grill bricks; (2) clean open burners by washing in a grease solvent; (3) keep petcocks tight and replace immediately if broken; (4) clean ovens daily, removing racks and bottom pans if necessary; (5) in large electric ovens, the steel plate may come out in periodic cleanings but may be scraped daily; (6) leave oven doors ajar for a little when beginning to heat, as this will prevent condensation.

Deep Fat Fryers: (1) Drain daily so that grease may be strained; (2) wipe out fryers.

USE SOAP AND WATER

In the case of floor mats or racks, the care will depend on the material. Hot soap and water should be used for wood; hot soap and water for rubber; hot soap and water for leather, followed by an application of neat's-foot oil.

Steam Equipment: Check gaskets; if not stainless metal or enamel, keep oiled to prevent rusting.

Meat Saws and Cutters: Daily cleaning is the best protection; also, proper use of the machine. French bread will dull the best blade. (We cut dozens of loaves daily on a meat saw, however.)

China, Glass, Silver, Plastic: Many of us who suffer with hard water problems have maintenance on these items. In addition to washing, it is necessary to "dip" for stain removal unless some of the new products on the market make it unnecessary.

We could go on indefinitely but to summarize in a few words: Have adequate equipment records; teach employees proper use and care of equipment; have a maintenance program weekly, monthly and yearly, and in training always remember the words of the old preacher: "I tells 'em I'm goin' to tell 'em. I tells 'em. I tells 'em I tole 'em."



New Food Conveyor Brings You These Advantages of Selective Menu Service

EVERY DAY more hospitals are learning the "Selective Menu" lesson. The experience of many institutions proves that providing a choice of foods and getting them to the patient in palatable form has important advantages. For one thing, patients' morale is improved and recovery is speeded. There's more appetite appeal, less food waste, greater satisfaction with your hospital's service.

ONE CONVEYOR, MANY TOP ARRANGEMENTS — The Blickman "Selective Menu" Food Conveyor has been specially designed to provide a variety of foods for selective menus. It is built entirely of stainless steel. Square and rectangular pans, furnished with each conveyor, can be arranged in different ways within each of the two rectangular wells. Combinations can be varied according to the food requirements for any given meal. Since it transports food in bulk, fewer trips are required, reducing elevator use considerably during mealtime.

NEW, SEAMLESS, SANITARY TOP — The "Selective Menu" Food Conveyor also achieves high standards of sanitation with the new crevice-free, sanitary top. All surfaces are smooth and continuous where wells meet the top deck. Thus dirt-collecting traps around wells found in ordinary construction are entirely eliminated. Why not investigate the unusual features of this new conveyor now? . . . Write for helpful booklet.

- Patients Enjoy Food
- Meals Are More Palatable
- Menu Has Greater Variety
- Less Food Is Wasted
- Elevator Loads Are Reduced



CHOOSE the top deck arrangement needed for any specific menu. Variety of sizes in square and rectangular insets permits flexibility in accommodating a number of vegetables, meats, fish, potatoes, soup and broth.



SEAMLESS, crevice-free, sanitary top—all wells are part of the top deck, forming smooth, continuous, crevice-free surfaces where they join the top. Cleaning is simple and quick.



"Selective Menu" Food Conveyor at Stamford (Conn.) Hospital. Nurses carry trays from diet kitchen to patients with food that is hot and appetizing.

Send
for
Catalog



Send for helpful descriptive literature explaining merits of the "Selective Menu" and describing this and other Blickman-Built Food Conveyors.

S. Blickman, Inc.,
1503 Gregory Ave., Weehawken, N. J.

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FOOD SERVICE EQUIPMENT



COFFEE URNS



STEAM TABLES



FOOD CONVEYORS



SINKS



WORK TABLES

You are welcome to our exhibit at the New England Hospital Assembly, Hancock Room, Hotel Statler, Boston, Mass., March 24-26 and to the Southeastern Hospital Conference, Biltmore Hotel, Atlanta, Ga., April 16-18.

Menus for April 1952

Mrs. Eleanor Pickard

Dietitian
Naevs Hospital
Albert Lea, Minn.

<p>1 Apricot Nectar Soft Cooked Egg</p> <p>•</p> <p>Beef Stew Mashed Potatoes Buttered Green Beans Tomato, Cucumber Salad With Roquefort Dressing Deep-Dish Apple Pie</p> <p>•</p> <p>Cream of Asparagus Soup Assorted Cold Cuts Potato Salad Radishes, Celery Angel Cake Frozen Strawberries</p>	<p>2 Orange Slices French Toast, Sirup</p> <p>•</p> <p>Stuffed Pork Tenderloin Baked Potatoes Grilled Tomatoes Pineapple, Cabbage Slaw Orange Bavarian Cream</p> <p>•</p> <p>Vegetable Soup Barbecued Beef on Bun Tossed Salad With 1000 Island Dressing Prune Plums Sugar Cookies</p>	<p>3 Grapefruit Juice Poached Egg</p> <p>•</p> <p>Baked Ham With Spiced Grapes Escalloped Potatoes Lima Beans Golden Glow Salad Vanilla Ice Cream With Chocolate Sauce</p> <p>•</p> <p>Consommé Cheese Fondue Stuffed Green Pepper Head Lettuce With French Dressing Fresh Fruit Cup Frosted Brownies</p>	<p>4 Prunes Scrambled Eggs</p> <p>•</p> <p>Salmon Loaf With Egg Sauce Whipped Potatoes Peas Spiced Crabapples Lemon Soufflé With Whipped Cream</p> <p>•</p> <p>Cream of Celery Soup Shrimp Creole With Steamed Rice Sliced Orange Salad Coffee Cake Nectarines</p>	<p>5 Orange Juice Soft Cooked Egg</p> <p>•</p> <p>Pot Roast of Beef Parslaid New Potatoes Buttered Carrots Lettuce Wedge With Russian Dressing Date Caramel Pudding</p> <p>•</p> <p>Pork Sausage Patties Escalloped Corn Pickled Beets Oatmeal Cookies Sliced Bananas</p>	<p>6 Grapefruit Halves Bacon, Coffee Roll</p> <p>•</p> <p>Roast Chicken With Dressing Mashed Potatoes Asparagus Cranberry Sauce Orange Sherbet Wafers</p> <p>•</p> <p>Cream of Potato Soup Large Fruit Salad Grilled Cheese Sandwich Lemon Roll With Whipped Cream</p>
<p>7 Baked Apple, Cream Ham Omelet</p> <p>•</p> <p>Breaded Veal Cutlets Delmonico Potatoes Buttered Cauliflower Diced Peas in Lime Gelatin Baked Custard</p> <p>•</p> <p>Chicken Chow Mein With Fried Noodles Tossed Salad With French Dressing Sliced Peaches Ice Box Cookies</p>	<p>8 Orange Sections Poached Egg</p> <p>•</p> <p>Norwegian Meat Ball With Gravy Buttered Noodles Wax Beans Celery, Carrot Sticks Apple Crisp With Whipped Cream</p> <p>•</p> <p>Blended Juice Creamed Chipped Beef Baked Potatoes Julienne Vegetable Salad Boysenberries Date Bars</p>	<p>9 Grape Juice Griddle Cakes, Pork Links</p> <p>•</p> <p>Roast Beef With Horseradish Sauce Franconia Potatoes Buttered Beets Spiced Peaches Buttercrunch Ice Cream</p> <p>•</p> <p>Spaghetti With Meat Sauce Grapefruit, Orange Salad Apricot Whip Pecan Cookies</p>	<p>10 Stewed Rhubarb Poached Egg</p> <p>•</p> <p>Meat Pie Parslaid Potatoes Kernel Corn Radish Roses, Pickles Tapioca Cream With Frozen Raspberries</p> <p>•</p> <p>Cream of Mushroom Soup Grilled Spiced Meat and Sliced Cheese on Buns Stuffed Tomato Salad Pineapple Chunks Frosted Cup Cakes</p>	<p>11 Mandarin Orange Sections Soft Cooked Egg</p> <p>•</p> <p>Fried Haddock With Tartare Sauce Creamed Potatoes Frozen Broccoli Pickled Beet Salad Fillet Oatmeal Cookies Green Gage Plums</p> <p>•</p> <p>Cream of Pea Soup Tunafish Salad Shoestring Potatoes Tomato Aspic Gingerbread With Lemon Sauce</p>	<p>12 Grapefruit Juice Scrambled Eggs</p> <p>•</p> <p>Barbecued Ribs Boiled New Potatoes Sauerkraut Fruit Gelatin With Whipped Cream</p> <p>•</p> <p>Vegetable Juice Cocktail Hot Roast Beef Sandwich With Gravy Cauliflower au Gratin Tossed Salad Royal Anne Cherries Sponge Cake</p>
<p>13 Apricot Nectar Bacon, Butter Fluffs</p> <p>•</p> <p>Baked Ham With Pineapple Rings Baked Potatoes Minted Green Peas Celery, Stuffed Olives Lemon Chiffon Pie</p> <p>•</p> <p>Vegetable Soup Large Fruit Salad Boston Brown Bread With Roquefort Spread Vanilla Ice Cream Chocolate Brownies</p>	<p>14 Grape Juice Poached Egg</p> <p>•</p> <p>Meat Loaf Macaroni and Tomatoes Tossed Salad With French Dressing Chocolate Bread Pudding With Meringue</p> <p>•</p> <p>Split Pea Soup French Toast, Sirup Canadian Bacon Apple, Celery and Pineapple Salad With Combination Dressing Black Raspberries Peanut Cookies</p>	<p>15 Sliced Bananas Soft Cooked Eggs</p> <p>•</p> <p>Stuffed Flank Steak With Gravy Cottage Fried Potatoes Parslaid Carrots Cabbage, Green Pepper Slaw Vanilla Pudding With Frozen Peaches</p> <p>•</p> <p>Fruit Punch Corned Beef Hash Poached Egg Sliced Tomato Salad Bran Muffins Strawberry Preserves</p>	<p>16 Prunes Scrambled Eggs</p> <p>•</p> <p>Veal Cutlets With Tomato Sauce Potatoes O'Brien Whole Kernel Corn Waldorf Salad Tapioca Cream</p> <p>•</p> <p>Vegetable Soup Ham Salad Sandwiches Potato Chips Dill Pickle Strips Banana, Orange, Nut Salad Macaroons</p>	<p>17 Orange Juice Soft Cooked Egg</p> <p>•</p> <p>Liver and Bacon Baked Potatoes Harvard Beets Jellied Grapefruit Salad Chocolate Nut Sundae</p> <p>•</p> <p>Chicken à la King on Steamed Rice Green Beans Spiced Peas Raspberry Shortcake</p>	<p>18 Grape Juice Griddle Cakes, Sirup</p> <p>•</p> <p>Halibut, Lemon Wedges Creamed Potatoes Spinach Celery Curli, Pickles Deep-Fish Rhubarb Pie</p> <p>•</p> <p>Garden Soup Macaroni Salad Deviled Eggs Tomatoes, Cucumbers Prune Plums Sugar Cookies</p>
<p>19 Apple Juice Poached Egg</p> <p>•</p> <p>Swiss Steak With Onion Gravy Mashed Potatoes Brussels Sprouts Tossed Salad With French Dressing Cottage Pudding With Orange Sauce</p> <p>•</p> <p>Fruit Punch Chili Con Carne Cole Slaw Sweet Rolls Fresh Cup Cake</p>	<p>20 Pineapple Juice Sausage Links, Rolls</p> <p>•</p> <p>Roast Turkey With Dressing, Giblet Gravy Mashed Potatoes Green Beans Cranberry, Orange Relish Vanilla Ice Cream With Peach Sauce</p> <p>•</p> <p>Cream of Corn Soup Jellied Shrimp Potato, Green Pepper Salad Stuffed Celery Fresh Pineapple Spice Bars</p>	<p>21 Orange Halves Soft Cooked Egg</p> <p>•</p> <p>Roast Leg of Lamb Potatoes au Gratin With Mint Jelly Frozen Mixed Vegetables Orange, Endive Salad Coffee Gelatin With Whipped Cream</p> <p>•</p> <p>Consommé Turkey Shortcake Broccoli, Lemon Butter Gingerale Salad Bing Cherries White Cake</p>	<p>22 Grapefruit Sections Omelet</p> <p>•</p> <p>Minute Steaks Oven Browned Potatoes Cauliflower With Cheese Sauce Blushing Pear Salad English Apple Pie With Vanilla Sauce</p> <p>•</p> <p>Chicken Gumbo Soup Toasted Bacon and Tomato Sandwich Stuffed Celery Frozen Peaches Oatmeal Cookies</p>	<p>23 Sliced Bananas Grilled Ham, Muffins</p> <p>•</p> <p>Braised Beef Short Ribs Buttered New Potatoes Julienne Minted Carrots Lettuce With 1000 Island Dressing Baked Rice Custard</p> <p>•</p> <p>Tomato Bisque Link Pork Sausages Escalloped Corn Glazed Apple Rings Sliced Apricots Jelly Roll</p>	<p>24 Grape Juice Poached Egg</p> <p>•</p> <p>Broiled Chopped Steak Baked Potatoes French Fried Onions Radish Roses, Pickles Butterscotch Sundae</p> <p>•</p> <p>Fruit Juice Mexican Pie Grated Vegetable Salad Applesauce Blueberry Muffins</p>
<p>25 Orange Juice French Toast, Sirup</p> <p>•</p> <p>Fried Smelt With Tartare Sauce Whipped Potatoes Broiled Tomatoes Sliced Cucumbers Lemon Pie</p> <p>•</p> <p>Vegetable Juice Potato, Salmon Escalloped Asparagus Tips With Mayonaisse Baked Rhubarb, Pineapple Ginger Cookies</p>	<p>26 Prunes Scrambled Eggs</p> <p>•</p> <p>Curried Chicken Steamed Rice Diced Carrots, Peas Lettuce With French Dressing Pineapple Ice Box Dessert</p> <p>•</p> <p>Chicken Broth Cold Cuts Macaroni and Cheese Jellied Grape Salad Boysenberries Oatmeal Fingers</p>	<p>27 Apple Juice Soft Cooked Egg</p> <p>•</p> <p>Roast Beef Pan Browned Potatoes Creamed Spinach Green Pepper Relish Strawberry Shortcake</p> <p>•</p> <p>Split Pea Soup Deviled Ham on Toast With Sliced Egg Garnish Tossed Greens Grapefruit Sections Devil's Food Cake</p>	<p>28 Grape Juice Bacon, Brioche</p> <p>•</p> <p>Veal Loaf Potato Cakes Hot Pickled Beets Cole Slaw Lemon Sherbet Vanilla Wafers</p> <p>•</p> <p>French Onion Soup With Crostons Large Fruit Salad With Sliced Cheese Honey Biscuits Custard</p>	<p>29 Apricot Nectar Poached Egg</p> <p>•</p> <p>Breaded Pork Chop With Applesauce Mashed Potatoes Paprika Cauliflower Jellied Vegetable Salad Norwegian Prune Pudding</p> <p>•</p> <p>Cream of Corn Soup Hamburg on Buns Potato Chips Tomato Wedges Fresh Fruit Cup Spice Cake</p>	<p>30 Bananas in Orange Juice Omelet, Cinnamon Rolls</p> <p>•</p> <p>Baked Ham With Spiced Grape Sauce Escalloped Potatoes Lima Beans Peachstone Salad Ginger Bavarian Cream</p> <p>•</p> <p>Vegetable Soup Potato Pancakes, Sirup Canadian Bacon Celery, Pickles Chocolate Mint Roll</p>

Ready-to-eat or cooked cereals are offered on all breakfast menus.

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Individual
Servings...

DANDY OYSTER CRACKERS



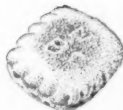
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● The right-sized portion for the average serving of soup ... chowder ... chili ... oysters and clams

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NATIONAL BISCUIT COMPANY

AIR RECOVERY improves ventilation

conserves heat and cuts fuel costs

JOHN E. MILLER

Chief, Services Section
Building Division
Department of Administration
Lansing, Mich.

THE American Society of Heating and Ventilating Engineers defines ventilation as "The process of supplying or removing air by natural or mechanical means, to or from any space." To which might be added, "in order to maintain a pleasant, agreeable atmosphere."

During periods of the year when there is not too much variation between outdoor temperatures and those required indoors, ventilation is usually simply a matter of opening enough doors and windows to obtain sufficient air movement. However, during the heating season ventilation can become a problem. Any new outside air that is drawn into a building must replace an equivalent amount of indoor air

and the air that is thus replaced carries with it the heating energy and hence the money that has been spent on it. In hospitals, particularly those for mental and geriatric patients, there is obviously a definite need for ventilation. Occupancy is relatively high and odor generation is considerable. Ensuring reasonably good atmospheres in such buildings and conserving fuel at the same time would appear to be somewhat like "eating your cake and having it too."

In Pontiac State Hospital, Pontiac,

Mich., a mental institution, there are several buildings which were erected in 1878. These structures had, until recently, the same gravity heating and ventilating systems that were installed at that time. On each side of the basement were louver dampers which controlled the entry of outdoor air into large plenum or reservoir areas where it was heated by being passed over steam heated cast iron coils and thence entered ducts leading up into the corridors and rooms. From these spaces other ducts conveyed the heated air to the attic areas where it was exhausted through roof ventilators. Both heat and ventilation were regulated by the opening and closing of the basement dampers. During severe weather when more heat was required more cold outside air would have to be admitted to obtain a greater "stack" effect, that is, take advantage of the tendency of warm air to rise.

Although heat and ventilation were fairly well maintained by this rather simple and crude system a certain amount of attention and manual operation of the dampers were always required. Good wind conditions were a necessity and it was often a question on which side of the buildings to open the basement dampers. Moreover, the rapid passage of the warm air up through the building and out the roof ventilators and its continuous replacement by new cold air resulted in a high rate of heat loss and fuel consumption.

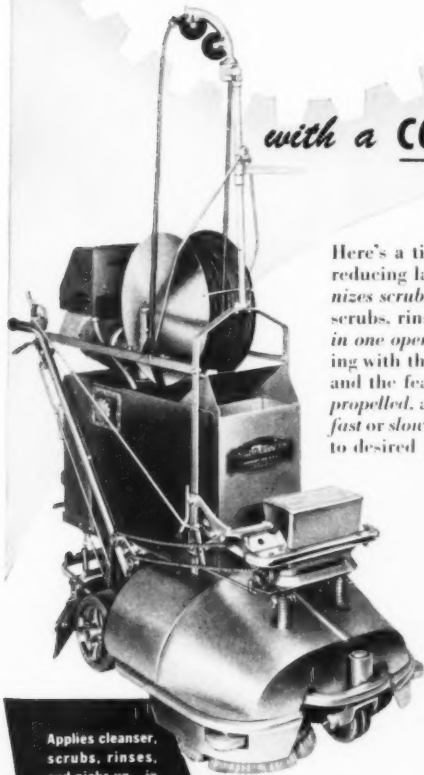
The function of ventilation air is to dilute the accumulated odors and not, as often commonly supposed, to provide oxygen. Actually, very little new air is needed for the human metabolism. Air that enters any enclosure by infiltration, that is, seepage through



Exterior view of Pontiac State Hospital, showing the ventilating stacks.

MECHANIZE 4 Scrubbing Operations into 1

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scrubs, rinses,
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ONE operation!

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Model 213P Scrubber-Vac at left, for heavy duty scrubbing of large-area floors, has a 26-inch brush spread, and cleans up to 3,750 sq. ft. per hour! (Powder dispenser is optional.) Finnell makes Scrubber-Vac Machines in a full range of sizes—and in self-powered as well as electric models. From this complete line, you can choose the size and model that's exactly right for your job (no need to over-buy or under-buy). It's also good to know that you can lease or purchase a Scrubber-Vac, and that there's a Finnell man nearby to help train your maintenance operators in the proper use of the machine and to make periodic check-ups. For demonstration, consultation, or literature, phone or write nearest Finnell Branch or Finnell System, Inc., 1103 East Street, Elkhart, Indiana. Branch Offices in all principal cities of the United States and Canada.

Conserve Manpower with Completely Mechanized Scrubbing

FINNELL SYSTEM, INC.

Originators of Power Scrubbing and Polishing Machines

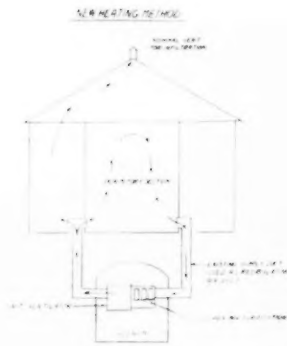
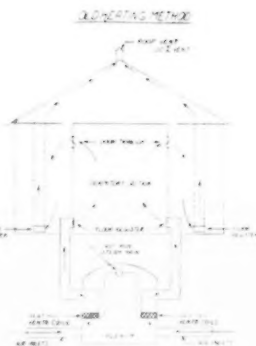


BRANCHES
IN ALL
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CITIES

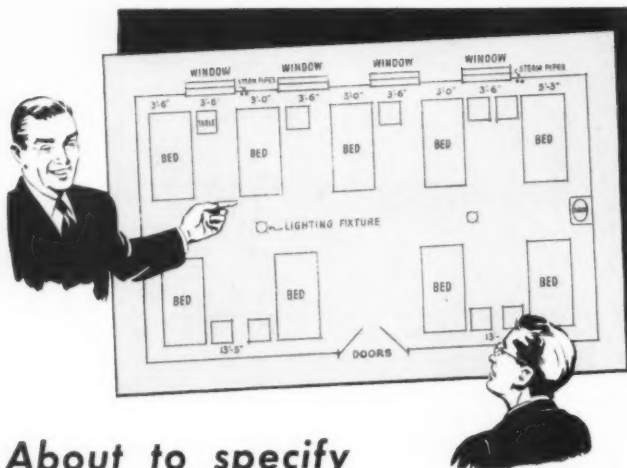
doors and windows, is usually adequate for oxygen replenishment even under the most crowded conditions.

Inasmuch as the purpose of ventilation is to reduce odor concentrations, the essential requisite of ventilation air is that it be odor-free. It need not be new outside air. This principle has made possible both good atmosphere control and fuel conservation in a number of the state of Michigan mental hospital buildings.

Several years ago, D. C. Milbourn, chief engineer at Pontiac State Hospital, decided that the old systems



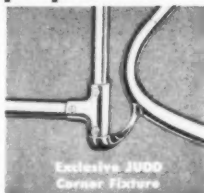
Diagrams showing the differences between the old and new methods of heating and ventilating used at the state hospital.



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were not providing comfortable conditions and at the same time were wasting or using up too much coal for heat. As an experiment, following discussions with me, he decided to replace the original coil arrangements with unit ventilators in one dormitory section. The roof ventilators were closed and some of the supply ducts were extended and linked up with the unit ventilators. Most of the supply ducts were converted to return air passages leading to the basement. Instead of pursuing its former one-way course through the building the heated air was channeled back to the basement for whatever reheating was necessary and again circulated. This new method resulted in substantial fuel savings and for the first time provided ample heat but it made no provision for ventilation. The construction of the building was such that some new air found its way in by infiltration. However, this air volume was far from being sufficient for ventilation in this type of hospital building. To correct the situation it was decided to install activated carbon "air recovery" units to purify the recirculated air.

A casing was constructed on the air entrance side of the heaters to house canisters containing activated carbon. Next, the return air ducts, which formerly simply opened into the basement, were lengthened and attached to the casing. The canisters were placed across the air stream in such a way that most of the air being drawn back from the building would have to pass uniformly and evenly through them. Thus a closed, continuous cycle type of heating and ventilat-

B.F. Goodrich



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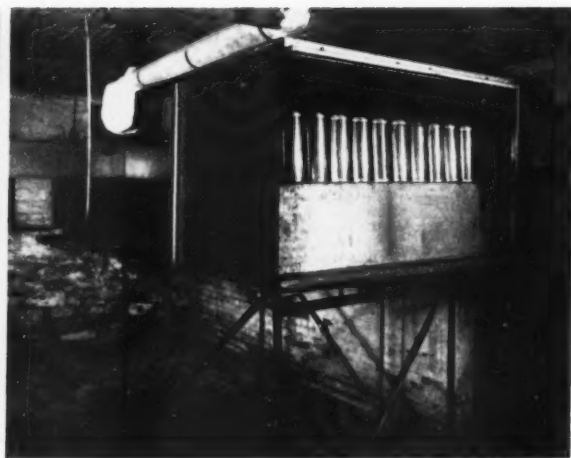
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Above, left: Original installation of wood boxed ventilating coils. Above, right: Showing adaptation of canisters to standard unit.

ing system was established, with the unit's blower forcing air up into the building and pulling it back again.

Despite the fact that a large proportion of the heated air was, in a sense, constantly being reused, observations of the atmosphere in this section of the building indicated that the odor level or air "quality" was better than that of the old system which relied on all new outside air. What was especially significant was a satisfactory heating and ventilating system plus a fuel saving, estimated at 90 tons of coal during an average winter for this one building.

The success of Mr. Milbourn's combined heating and ventilating installation, the first, it is believed, in a mental hospital to employ activated carbon filtration, led to its adoption in many other Pontiac State Hospital buildings, both old and new. Similar systems have also been installed in Caro State Hospital for epileptics and the geriatric building at Ypsilanti State Hospital. The new Northville State Hospital, which is under construction, is being completely equipped with activated carbon air recovery equipment. Although fuel records are not yet available, it is unquestionable that considerable economies will be shown in all installations.

In addition to the more obvious reasons for maintaining relatively odor-free environments in state institutions, studies suggest that odors, particularly unpleasant ones, are detrimental to health. In an experiment conducted by the John B. Pierce Laboratory of

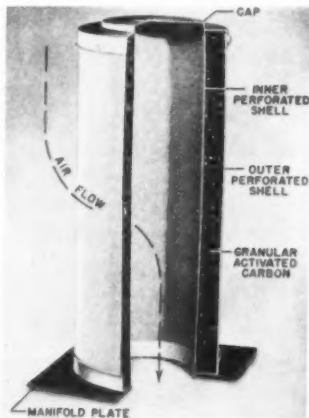
Hygiene, the odor of house dust, but not the dust itself, was introduced into a closed room in which the air was otherwise pure. Although the dust odor was admitted at a rate that was imperceptible to the occupants, comparisons with days when no odor entered the room showed that even a slight

odor level definitely caused a loss of appetite.

When it is realized that one part of odorous substances per million parts of air, or one ten-thousandth of 1 per cent, is enough to contaminate an entire atmosphere, the advantages of air purification become all the more evident. Instead of throwing away valuable heated air simply to get rid of this tiny percentage, the impurity itself is eliminated.

Activated carbon removes air-borne odors by the process of adsorption, the same principle used in the gas mask and in water purification, and is the most practical and efficient method yet developed. When odors (gases or vapors) come in contact with the surfaces of the carbon they condense and cling tenaciously. The type of activated carbon used in air purification is composed of myriads of submicroscopic pores or capillaries whose total surface area in a cubic inch has been estimated to be equivalent to five acres, making it a substance with relatively enormous odor-adsorptive properties.

As an integral part of the heating installations in quite a number of buildings of the mental hospitals of the state of Michigan, air recovery has proved extremely valuable in maintaining good ventilation standards and conserving fuel. Also, the initial and maintenance cost is considerably below that of equipment required to heat an equivalent volume of new outside air. It is estimated that the installations will pay for themselves within a few years.

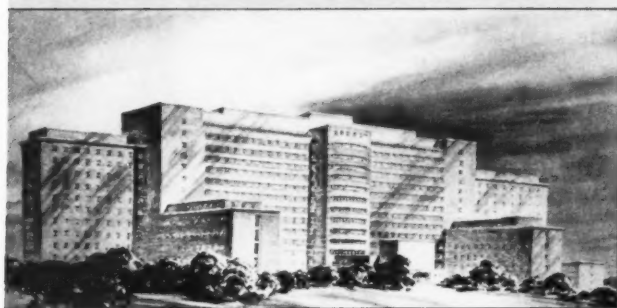


Cut-away view of the air purification canister shows how the air passes through a bed of activated carbon which extracts impurities, odors from the air.



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Builders' Hardware: W. C. Vaughan Co., Boston, Mass.

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For over a quarter century the leading architects in hospital design have specified Glynn-Johnson devices for door control. These devices are recommended for their distinctive appearance, increased quietness in the operation of doors, greater convenience for attendants, and for protection of the doors and walls.

For detailed descriptions and applications, refer to G-J catalog.



ROLLER LATCH



DOOR SILENCERS



CONCEALED FRICTION DOOR HOLDER



DOME BUMPER



ARM PULL



Glynn-Johnson Corporation

Builders' Hardware Specialists for Over 25 Years

4422 N. Ravenswood Ave.

Chicago 40, Illinois

G-J devices for all types of doors
in modern hospitals:

Friction Control Door Holders • Roller Latches • Arm
Pulls • Door Silencers • Bumpers • Transom Adjusters

Purchasing and Warehousing Procedure

takes the lost motion out of moving day

IRENE RUDULPH

Executive Housekeeper
St. Luke's Hospital
Milwaukee

THERE is a long road to be traveled between the day when it is decided to build a new hospital and the day when we must receive and place the equipment and supplies that have been purchased for the new structure. Too frequently, this phase of the building program is neglected until shipments actually begin to arrive; then a system is hastily improvised, and general confusion reigns as each department attempts to locate the various pieces of equipment that belong to it. Long after opening day the search goes on for furnishings and equipment that were placed in some area other than the one for which they were intended.

After the building has been opened for a while, and breakdowns occur from normal use, questions arise as to who the manufacturer was; where repairs or parts can be obtained; where to find necessary instructions for the special care of fabrics and materials. Unless there are complete and informative records, this state of confusion is likely to last as long as the building does.

The new St. Luke's Hospital now under construction in Milwaukee is being built with federal assistance, and lists of equipment needed had to be submitted for government approval. As we began to prepare these lists we became conscious of the great number of items to be purchased, warehoused and later placed in designated areas. Shortly after we began to build it was my privilege to assist with compiling the equipment lists, and during this time we discussed the need for organization in purchasing and the details which follow receipt of merchandise. Through discussion with M. E. Knisely, administrator of St. Luke's Hospital, and James Melzer, controller, this procedure was developed. Much thought was given to planning a system which we believe will facilitate this project and provide us with records for future reference.

Whether to do the buying ourselves

or to have outside people do it for us was considered first. It was finally decided to turn over the buying of all equipment to a hospital supply firm that specializes in this type of service. An interior decorator was selected who was to work through the chosen purchasing firm. The advantages to us are a considerable saving of our time, and the fact that the direct contact which the hospital supply firm has with manufacturers gives us better quality and selection because each product is screened before it is submitted to St. Luke's Hospital for approval to purchase. Each department was asked by the purchasing firm for specifications; samples and models were presented for inspection. The interior decorators requested the hospital to determine the kind of furniture, furnishings, color styling and general decor desired. At no time have we forfeited the privilege of making our own specifications, selections and decisions.

The benefits of our procedure will not cease when we open the doors to admit patients into the new hospital.

PURCHASING FIRM

PROJECT: St. Luke's Hospital
29th & W. Oklahoma
Milwaukee, Wis.

CATALOG LIST FOR PURCHASING

[illegible]

80,000

~~OVER 70,000 IN USE~~

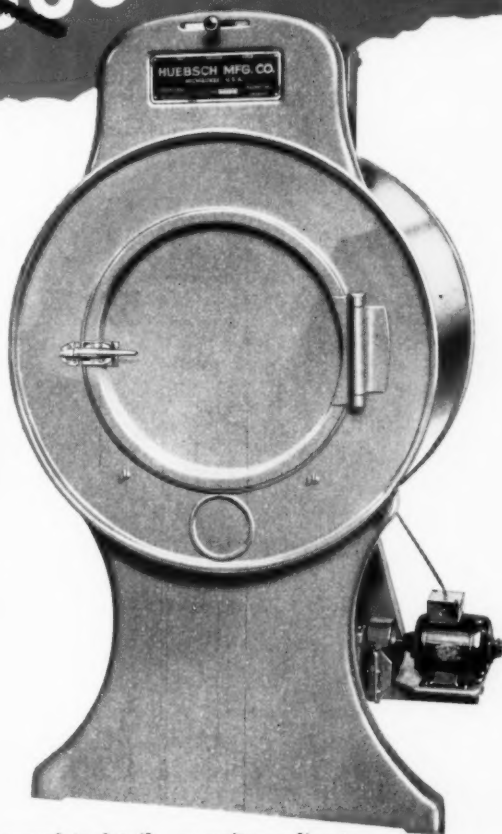
Correction please! We've been saying: "Over 70,000 Huebsch Tumblers in Use." That number has grown to 80,000—and is growing larger every day. For commercial and self-service laundries...for dry cleaning use...for institutional work...you can't buy better than Huebsch. The sales *prove* it.

HUEBSCH

OPEN-END

TUMBLERS

If you're looking for faster drying, easier and faster loading and unloading, low initial cost and low maintenance cost—you'll find the answer in Huebsch Open-End Tumblers. Steam-heated or gas-heated models, in choices of four sizes: 36" x 18", 36" x 24", 36" x 30", 42" x 42".



Ask your Huebsch representative for complete details—or write us direct

HUEBSCH
Originators

INVENTOR AND WORLD'S LARGEST MANUFACTURER OF OPEN-END DRYING TUMBLERS

Makers of the famous Huebsch Handkerchief Ironer and Fluffer • Pants Shaper
Automatic Valves • Feather Renovator • Double Sleever • Collar Shaper
and Ironer • Garment Bagger • Cabinet and Garment Dryers
Washometer • Spring-Type Filter

HUEBSCH MANUFACTURING COMPANY, 3776 N. Halsted St., Milwaukee 1, Wis.

Div. of THE AMERICAN LAUNDRY MACHINERY CO.

St. Luke's Hospital
29th & W. Oklahoma
Milwaukee, Wis.

Date

DAILY RECEIVING RECORD

Catalog No.	P. O. No.	Area No.	File No.	Company	Item	Quantity Rec.	Unit	Storage Area	Section	Row
-------------	-----------	----------	----------	---------	------	---------------	------	--------------	---------	-----

Filed by:

Received by:

PURCHASING FIRM

PROJECT: St. Luke's Hospital
29th & W. Oklahoma
Milwaukee, Wis.

MASTER EQUIPMENT RECORD

PURCHASING DATA

ACCOUNTING DATA

WAREHOUSE DATA

Item	Cat. No.	P. O. No.	Area No.	Quan.	Unit	Price	Amt.	File No.	Date Rec.	Qt. Rec.	B. O.	Inv. No.	Inv. Date	Inv. Paid	Fr. Inv. Date	Sta. Area	Sec. tion	Row	Equip-ment Tag No.	With-drawal Date	Requi-sition No.
------	----------	-----------	----------	-------	------	-------	------	----------	-----------	----------	-------	----------	-----------	-----------	---------------	-----------	-----------	-----	--------------------	------------------	------------------

REQUEST FOR TRANSFER OF EQUIPMENT

Article: _____ Equipment Tag No. _____

From: _____ To: _____

Requested by _____ Approved _____

Transfer Effective Date _____ Equipment Ledger Checked _____

ST. LUKE'S HOSPITAL
29th & W. Oklahoma

inasmuch as our controller has developed an "Equipment Ledger Card" for each piece of equipment purchased. This card will show date of purchase, cost, manufacturer, model, serial number, location and other pertinent information. The lower half of the card will carry a record of asset value, depreciation value, and reserve value. The reverse side of the card is a maintenance record showing the history of

repairs, replacement of parts, labor and cost.

The details for setting up the equipment ledger card will be taken from the master equipment record as it is processed through the channels hereafter described in the "Purchasing Procedure." The equipment ledger card will be a permanent record of location of any given piece of equipment. Should it be determined later that a

piece of equipment could be better used in another area this will be effected by a "Transfer of Equipment" notice. Upon receipt of this approved transfer the equipment ledger card will be adjusted to show the exact location of the item; thus we will have a permanent current-to-date record of every piece of equipment in the hospital.

In addition to facilitating our present ambition to purchase, warehouse and place equipment in correct order, we will have established a complete history of each item of equipment which will furnish any information that may be desired as it pertains to accounting, usage and maintenance, for the life of the item. Such a record will not be lost in the event of changes in personnel, and will enhance the efficiency of the hospital.

The outline of the purchasing procedure follows on pages 144 and 146.

Sealy

... America's only bedding line designed specifically for the Contract Field!



**WITH 27 DIFFERENT PLANTS FOR
GREATEST ECONOMY!...**



*Announces the
Inauguration of the
Sealy Mattress
Contract Division*

- * Allston, Massachusetts
- * Baltimore, Maryland
- * Bluefield, Virginia
- * Brooklyn, New York
- * Charlotte, N. Carolina
- * Chester, Pennsylvania
- * Chicago, Illinois
- * Cleveland, Ohio
- * Denver, Colorado
- * Des Moines, Iowa
- * Detroit, Michigan
- * Fort Worth, Texas
- * Houston, Texas
- * Kansas City, Missouri
- * Los Angeles, California
- * Louisville, Kentucky
- * Memphis, Tennessee
- * Oakland, California
- * Paterson, New Jersey
- * Pittsburgh, Pennsylvania
- * Portland, Oregon
- * Reading, Pennsylvania
- * Richmond, Virginia
- * Rochester, New York
- * St. Paul, Minnesota
- * Schenectady, New York
- * Waterbury, Connecticut

Since 1884

★ For 71 distinguished years Sealy has manufactured bedding to meet the highest demands of consumer quality and acceptance. For the past four and one-half years, Sealy has been pioneering in the research and engineering of bedding requirements for America's service institutions. Now, after intensive study and plans, Sealy . . . with the 27 strategically located plants that comprise the Sealy system . . . is finally ready to provide bedding with the durability, comfort and economy demanded by institutional standards. This exclusive Sealy service merits your investigation today.



Sealy, Inc., Dept. MH-3
666 Lake Shore Drive, Chicago, Ill.

Gentlemen:

Please tell me how I may obtain further information about the new Sealy Contract Division merchandise and service plus a copy of the Sealy Institutional Bedding Catalogue. Address me as follows:

NAME _____

ADDRESS _____

POSITION AT SERVICE INSTITUTION _____

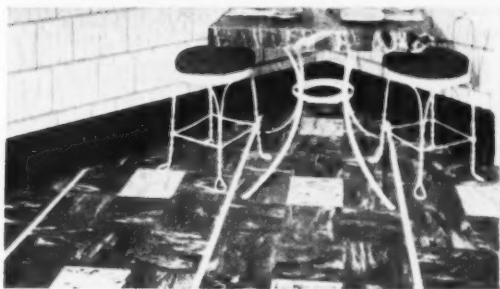
CITY _____

STATE _____

The MODERN HOSPITAL



More Flair Less Care



SMARTLY DESIGNED, colorful, sparkling-clean! Floors like these really dress up a restaurant or cafeteria...make a kitchen gleam, a corridor shine, a reception room glow!

And think of the big savings in maintenance you'll get from this durable flooring made of VINYLITE Brand Resins!

It far outlasts other resilient floor coverings. The non-porous, tough surface cleans with a swish. Waxing gives it an incomparable lustre, though waxing is not necessary, since dirt cannot penetrate. The hard finish resists water, soap, grease and cleansers—even acid and strong alkali solutions.

You'll choose from an unlimited array of lasting colors with brighter, clearer tones than ever before possible in resilient floor covering. Tile and continuous flooring of VINYLITE Resins is always flexible, conforming to uneven wood floors and normal floor play without cracking. It can be applied to concrete that is in direct contact with the ground.

Such qualities make VINYLITE Brand Resins useful for scores of products for defense and basic industry. Let us send you a list of suppliers of these floor coverings now. Write Dept. LW-85.

Photographs and data on "Terraflex" flooring courtesy Johns-Manville Sales Corporation, 22 East 40th Street, New York, N. Y.

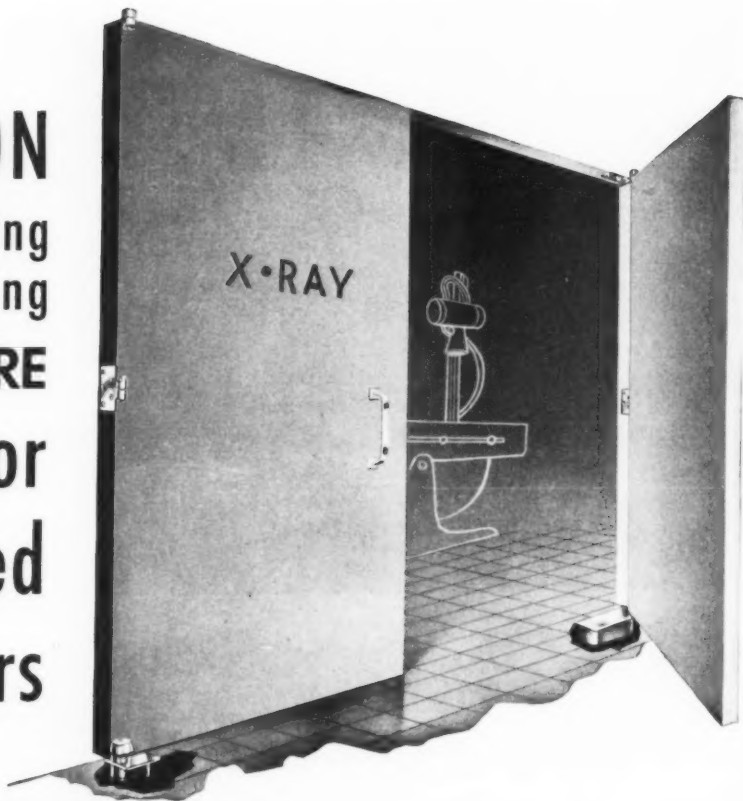
Be sure to visit BAKELITE'S Exhibit, Booth 314-324, National Plastics Exposition, Philadelphia, March 11-14.

Vinylite
BRAND
RESINS

TRADE MARK

BAKELITE COMPANY, A Division of Union Carbide and Carbon Corporation **UCC** 30 East 42nd Street, New York 17, New York

RIXSON door closing door hanging HARDWARE for lead-lined doors



*double row
of bearings



L 19
*extra wide leaves



*precision bearings

L25 CHECKING FLOOR HINGE
Single acting—Offset type
AUTOMATIC DOOR CLOSING
recommended for active door (at right)

L117 PIVOT SET
Single acting — Offset type
DOOR HANGING ONLY
recommended for inactive door (at left)

* built to carry EXTRA HEAVY doors

Two famous precision-made Rixson products. The L-25 that keeps heavy X-ray doors under constant control and brings them to a quiet close after each opening. The L117 that provides safe hanging for heavy X-ray doors not requiring a closing device. Three rows of bearings support the spindles of both the L25 and L117. Two rows of bearings in the top pivot keep the door in safe alignment. The L19 is usually recommended for extra alignment support.

Write for complete details . . .

THE OSCAR C.

RIXSON

COMPANY

4450 W. Carroll Avenue • Chicago 24, Illinois

GARLAND Broilers Lead by 35%

in a nationwide survey of restaurants recommended by



Duncan Hines

Restaurants recommended by this famous food authority were asked: "What commercial broilers do you use?"

1. Garland was named 35% more times than the next make.
2. Garland had 34% more broilers in use than the next make

DUNCAN HINES, nationally known connoisseur of fine food and author of, "Adventures In Good Eating," "Lodging For a Night," "Vacation Guide," "Adventures In Good Cooking and The Art of Carving in the Home." Travelers have learned to depend upon his Official Identification Sign as a sure guide to "Good Eating."



Provides More Uniformly Intense Heat Over Greater Area!

ONLY GARLAND gives you all the advantages of *Infra-Amic Side Firing Broiler*! Separately controlled multi-jet burners—one on each side—shoot the flame across a specially designed ceramic area. The infrared heat is radiated downward from the ceramics over the entire grid area! This provides maximum intensity of heat combined with maximum uniformity of heat! No wonder it's first choice of restaurants recommended by Duncan Hines, Leading Food Service Equipment Dealers everywhere recommend and sell Garland, the Leader!

ALL GARLAND UNITS ARE AVAILABLE IN STAINLESS STEEL and equipped for use with Manufactured, Natural or LP Gases

- ★ New Multi-jet Burners Provide Faster Broiling!
- ★ "Floating" Grid Rods Prevent Warping Under Heat!
- ★ Burners Located Out of Grease Spatter Zone!
- ★ Grid Control Lever Located Out of Heat Zone!
- ★ Unbroken Exterior for Easier, Faster Cleaning!

Ask your dealer for "Proof of Profits" through use of modern Garland Gas equipment.



WHY GARLAND BUILT IS BETTER BUILT

REASON NO. 2: Oven Insulation material is rodent-proof and enclosed in special metal housings. Prevents sagging, odor penetration. Keeps kitchen cooler, insures uniform oven temperature.

GARLAND

DM
PRODUCTS

Heavy Duty Ranges • Restaurant Ranges • Broiler Roasters • Deep Fat Fryers • Broiler-Griddles • Roasting Ovens • Griddles • Counter Griddles • Dinette Ranges
DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN

EQUIPMENT LEDGER

Item	Model	Tag No.
Manufacturer	Serial No.	Floor No.
Address	Other Data	Department
Purchase Order No.		Room No.
Invoice No.	Voucher No.	Date Rec'd
Account No.		Transfers
Total Cost: \$	Est. Life:	yrs. Depreciation per Yr.: \$
		Mo.:

[illegible]

Luke's Hospital (2 copies). Information pertinent to this record will be forwarded per procedure outlined.

(a) PURCHASING DATA

Upon initiation of a purchase order, St. Luke's Hospital will enter this information in the purchasing data section according to the detail form.

Purchase order is then forwarded to Purchasing Firm for its purchase data recording and processing of purchase.

(b) ACCOUNTING DATA

1. *Receiving* information will be supplied daily by Receiving Clerk to Purchasing Firm and St. Luke's Hospital.

2. *Invoices* for merchandise will be received by Purchasing Firm and recorded in its copy of accounting data. Invoice is then forwarded to St. Luke's Hospital for accounting department processing and record.

3. *Freight Charges* will be included with invoice whenever possible.

Freight invoices, when not a part of ORIGINAL INVOICE, will be forwarded

to St. Luke's Hospital by Purchasing Firm.

Freight invoices will be identified by the ORIGINAL INVOICE number, followed by the letter "A."

Proper entry will be made in the accounting data section.

WAREHOUSE DATA

Shipments of merchandise to be received on and after April 1, 1952, at St. Luke's Hospital, So. 29th & W. Oklahoma Avenue, Milwaukee. All shipments to be completed June 15, 1952.

A receiving clerk will be appointed to receive and check shipments delivered. Shipments will be checked per detail on the daily receiving record:

- Purchase order number
- Equipment area number
- File number (department)
- Catalog number
- Vendor
- Items, quantity and description
- Warehouse and storage detail

Copies of daily receiving record will be forwarded each day to:

Purchasing Firm (1 copy)
St. Luke's Hospital (2 copies)
1—Accounting Department
1—Receiving Department

Entry will be made in the warehouse data section of such information as is contained on the daily receiving record.

WITHDRAWAL RECORD

All merchandise removed from warehouse will be drawn on a special "Equipment Removal" form which will show:

Item and quantity removed
Equipment area number
Equipment tag number (permanent
record number)
Equipment removal form number

Copies of equipment removal form will be sent to St. Luke's Hospital—Accounting Department, Receiving Department.

Your senses tell you

Three of the five senses with which we are all endowed give quick, unmistakable evidence of Ivory Soap's fineness.

— it's a finer soap!



YOUR EYES receive the first favorable impression of Ivory. The white, trimly designed cake has a pleasing, inviting "quality look".



NOW SMELL Ivory. There's no hint of strong perfume. Fine ingredients are the answer to that clean, fresh odor.



PERFECT!

Finally, GRASP the Ivory cake in your fingers. See how perfectly it fits the hand . . . how soft it feels. Test its mild, generous lather.



Yes, these three senses tell you that Ivory is a pure, gentle soap . . . the kind of soap that belongs in an institution with your high standards.



*99⁴⁴/₁₀₀% pure
it floats*

Procter & Gamble

Ivory Soap is available for hospital use in the popular unwrapped 3-ounce size,* as well as in smaller sizes—wrapped or unwrapped.

*Packed weight.

MORE DOCTORS ADVISE IVORY SOAP THAN ALL OTHER BRANDS TOGETHER!

**"We're safeguarding lives - - and
saving time and money - - with
Scott DEMAND INHALATORS!"**

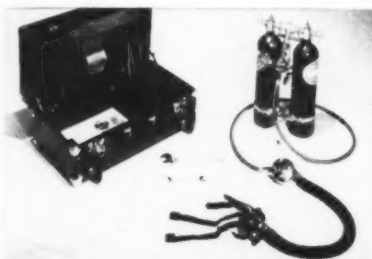


**PORTABLE or STATIONARY MODELS
PROVIDE RESPIRATORY ASSISTANCE
FOR PATIENTS - - - Anywhere!**

When *YOUR* patients need Oxygen-Inhalation Therapy the Scott Demand Inhalator will provide relief quickly, simply, safely and economically. No special training is required to use the SCOTT; there are no adjustments to set, no flow meters to watch. Oxygen therapy is initiated speedily and maintained as long as desired without waste of Doctor's or Nurse's time. The Scott Demand Inhalator auto-

matically conforms to the patient's own respiratory rate and tidal volume, delivering an abundance of oxygen to the mask **WITHOUT WASTE**. Oxygen economy (saving up to 50%) reduces cost of prolonged therapy.

Fully guaranteed for one year. Try for 30 days and if not satisfied, your money refunded without question.



Type B SCOTT Demand Inhalator (illustrated)—for portable use, including carrying case. Provides over one hour's emergency supply.



**CALL IN your Hospital Supply
Distributor or WRITE today for
complete information.**



FOR SAFETY—FOR SERVICE

SAFETY EQUIPMENT DIVISION

SCOTT AVIATION CORP.

259 ERIE ST., LANCASTER, N. Y.

CANADA: SAFETY SUPPLY CO., TORONTO — BRANCHES IN ALL PRINCIPAL CITIES
EXPORT: SOUTHERN OXYGEN CO., 157 Chambers Street, New York 7, N. Y.

Hospital of the Year

(Continued From Page 71.)

time was a much more difficult job than last year," another member wrote, "and I'm sure you're not going to find the same agreement among your judges."

Nevertheless, the Bristol Memorial was first selection of two committee members, second choice of a third member and third choice of the final judge. Criticizing the Bristol plan, the committee member who made this hospital his third choice commented as follows:

"The vote for third place goes to this hospital on the basis of a pleasing architectural appearance, its interesting plot plan layout, and the way the doctors' office building is integrated with the hospital. From the standpoint of workability of the nursing unit and lack of toilet facilities between each pair of rooms, I would have put this hospital out of the running; however, its other features offset this lack and it seemed to warrant one of the top places."

THE PROJECT WAS AN "ORPHAN"

Because Bristol is on the state line between Tennessee and Virginia, the hospital project became an "orphan" under the Hill-Burton program as it was originally projected. The population of Bristol is divided between the two states and a true picture of its importance and need for hospital facilities did not emerge in either of the original state hospital programs. After the hospital had been "disowned" by both states, however, an application was eventually accepted and approved by the Tennessee state hospital agency; this was for 80 beds, and a local fund-raising campaign was conducted to finance the additional beds required in the expanded plan.

Certificates in recognition of its selection as "Modern Hospital of the Year" have been awarded to the hospital, the architect and the state hospital planning agency. Mr. Aydelott has designed a number of hospitals in the United States and is presently engaged in planning a large hospital and medical center at Lima, Peru. In collaboration with Dr. Basil C. MacLean of the Strong Memorial Hospital, Rochester, N.Y., he designed an imaginative "Hospital of the Future" for The Modern Hospital several years ago.

New SKLAR ELECTRIC EVACUATOR

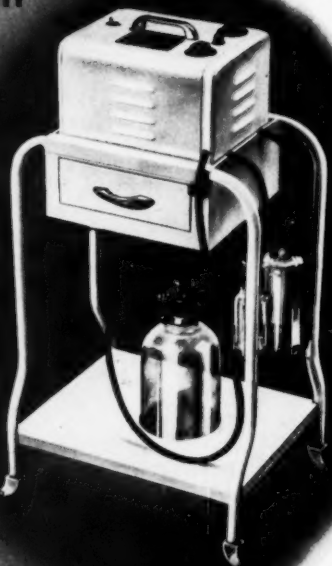
for Wangenstein
Technique

CAT. No. 155-100

The advanced development of this new compact, mobile Sklar Electric Evacuator is designed specifically to adequately provide for the many and variable indications for controlled low grade suction and pressure in preoperative and postoperative procedures.

The versatile and dependable performance of this essential unit, perfected after several years of research, fulfills the ever-present demand for these clinical requirements.

Available through accredited surgical supply distributors.



FEATURES

Pilot Light — Intermittent "On and Off"—Constant Visual Performance Check.

Performs Efficiently During Prolonged Continuous Use.

Range of Suction and Pressure Minutely Controlled.

Suction Calibrated from 50 to 250 cm. Water.

Motor Unit Automatically Ventilated.

Noiseless—Vibrationless.

Sklar Ivory-Baked Enamel Finish—Attractive in Appearance.

Gallon Size Suction Bottle—32 Ounce Irrigating Bottle—Trap Bottle.

Mobile—Stand Mounted on Casters.

No Maintenance or Lubrication Required.

TWO YEAR GUARANTEE

Sklar LONG ISLAND CITY, N. Y.

SURGICAL INSTRUMENTS... SUCTION PRESSURE AND ANESTHESIA APPARATUS... RESEARCH AND DEVELOPMENT



NEWS DIGEST

Health Care Program Discussed at A.H.A. Midyear Meeting . . . Propose Use of Drug Royalties to Help Medical Schools . . . Parenthood League Protests Action of Hospital . . . Wisconsin Hospital Association Honors Nels Hanshus

Universal Voluntary Health Insurance Program Urged at A.H.A. Midyear Meeting

CHICAGO.—Unless doctors and hospitals seriously mean what they say in their pronouncements about voluntary health insurance for all the people, they have no sound reason to oppose government health insurance; if they are serious about these pronouncements, they should be working with every possible agency, including the government, to develop a universal voluntary health insurance program.

This was the challenge laid down by E. A. vanSteenwyk, executive director of Philadelphia Blue Cross, in an address which was one of the principal features of the American Hospital Association's midyear conference of presidents and secretaries here last month. Mr. vanSteenwyk and Albert Whitehall, director of the A.H.A.'s Washington Service Bureau, discussed a proposed program for providing health care for dependents of servicemen through voluntary insurance plans.

As medical care has become more expensive, it has moved out of reach of many servicemen's families from the standpoint of cost, Mr. vanSteenwyk explained. These dependents have thus sought their hospital and medical care from the armed forces medical corps, forcing the military services to add hospital facilities. Actually, he said, armed forces authorities would prefer to have dependents of servicemen cared for in civilian facilities, possibly under armed forces' sponsorship, than to provide and manage such services themselves.

Mr. Whitehall pointed out that the present federal administration had offered little actual encouragement to voluntary health insurance plans. Federal employees are still not permitted to pay for voluntary health insurance by payroll deductions, and servicemen's dependents are not permitted to pay Blue Cross and Blue Shield premiums by pay allotments. Mr. Whitehall advocated a plan under which servicemen's families would be enrolled in Blue Cross and Blue Shield plans, paying one-half the sub-

scription fee for themselves and having the other half deducted from their pay while in government service. This plan, Mr. Whitehall said, would encourage servicemen to continue as members of voluntary health insurance plans after they return to civilian life.

At other meetings held during the two-day conference, more than 100 officers of local, state and regional hospital organizations heard discussions of current hospital problems and studied methods of obtaining maximum benefit from their cooperative efforts. During a discussion of hospital association activities, Mrs. Irene McCabe of St. Louis, executive secretary of the Missouri Hospital Association, urged the American Hospital Association to admit osteopathic hospitals to membership, inasmuch as these hospitals in some cases are already included in state hospital associations and Blue Cross plans.

Propose Use of Royalties on Drugs to Help Finance Medical Schools

CHICAGO.—The possibility that royalties on patented drugs and medical appliances might be used to help finance medical schools was presented here last month at the 48th annual Congress on Medical Education and Licensure of the American Medical Association. Dr. John W. Cline, A.M.A. president, said a special committee of the A.M.A. board of trustees was studying legal technicalities of the proposal. Provided no legal barrier is encountered, the proposed plan will shortly become a reality. Under the plan, the A.M.A. as a corporation would accept patents for medical developments submitted voluntarily by member physicians who may not themselves profit from such discoveries. Royalties would be turned over to the American Medical Education Foundation for eventual allocation to medical schools, Dr. Cline said.

Place of residence before admission to medical colleges is the leading factor in

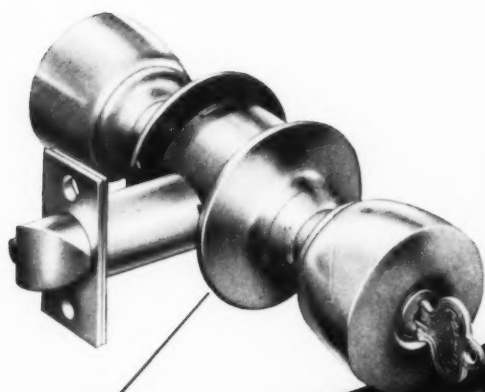
In discussion following this proposal, Dr. Frank Sutton, administrator of the Miami Valley Hospital, Dayton, Ohio, suggested that the training of osteopaths is improving rapidly to a point at which inclusion of osteopaths in the American Medical Association may not be far distant. Dr. Malcolm T. MacEachern, director of professional relations for the A.H.A., concurred, adding that a proposal has been made for physicians to assist in teaching programs at the three principal osteopathic schools. If the proposal is adopted, Dr. MacEachern said, these physicians will not be censured by medical organizations. Dr. MacEachern agreed that eventually osteopaths would be included in the American Medical Association.

Reporting on the activities of the Commission on Financing Hospital Care, of which he is director, Graham Davis said that a series of regional conferences had identified several principal

(Continued on Page 154)

determining the location of doctors' practices, Dr. A. G. Weiskotten said, reporting the results of a recent study of physicians' locations conducted by the Council on Medical Education and Hospitals. Thus an increase in medical school enrollments among students from small towns would be the most effective means of increasing the supply of doctors in rural areas and small towns, Dr. Weiskotten concluded. The study covered present locations of physicians graduating from medical schools in 1930, 1935 and 1940, it was explained.

Dr. Ward Darley, vice president of the University of Colorado and dean of the medical school, described an interstate agreement under which schools of medicine, dentistry, public health administration and veterinary medicine may exchange professional education services and assist one another in student placement. The interstate commission will also seek to integrate needs and resources for professional education facilities, Dr. Darley indicated.



1
When doors are in constant use, the new Russwin "Stilemaker" heavy duty Locksets offer special advantages. Their exclusive ball bearing pin tumbler cylinders assure trouble-free, long service life. Seamless tubular knob shanks provide full torsional strength . . . designed to eliminate wobble. Full $\frac{5}{8}$ " bolt throw handles extreme door shrinkage. Installation is easiest type. These advantages are typical of many offered by Russwin "Stilemakers".

4 easy ways to make hospital buildings more serviceable



4
Where safety is paramount, Russwin simplified Fire Exit Bolts assure top performance. They have only 3 sturdy, positively-aligned moving parts. Levers are drop-forged . . . dogging device is foolproof.



2
Where automatic door closing should be speed-regulated to fit the service, Russwin "400" Door Closers provide the answer. These precision-made, heavy-duty closers are the only closers with 4-speed control and "Silence Adjustment". Semi-concealed type has streamline appearance.



3
Where door holders are desirable, Russwin "Triple-Grip" Door Holders assure longer service life . . . fewer adjustments. Unique design provides twice frictional area of similar devices yet requires less pressure per square inch.

For complete details, check with your Russwin dealer or with Russell & Erwin Division, The American Hardware Corporation, New Britain, Conn. Russell & Erwin has manufactured a complete, quality line of Builders' Hardware for over a century.

SINCE 1839
RUSWIN[®]
DISTINCTIVE HARDWARE

NEWS...

Planned Parenthood League Protests "Discrimination" by Catholic Hospital

POUGHKEEPSIE, N. Y.—Issues of professional privilege and religious discrimination were raised in controversy here last month following action by St. Francis Hospital requesting that seven members of its medical staff either resign their staff memberships or discontinue their affiliation with the Dutchess County Planned Parenthood League.

Three of the seven doctors said they were resigning from membership in the planned parenthood league; four said they would retain their league memberships, it was reported.

Action by the hospital was immediately protested by the planned parenthood group. A league statement said the hospital's ultimatum to the doctors was "inconsistent with the character of an institution which has solicited funds from and professes to serve all faiths in the community."

Explaining the hospital's position, Sister Ann Roberta, administrator, said, "There is nothing new to the policy of St. Francis Hospital in dealing with planned parenthood. There is no controversy between St. Francis Hospital and any other group."

The hospital's views were further explained by the Rt. Rev. Msgr. Michael P. O'Shea of St. Peter's Church, Poughkeepsie. "Any qualified doctor may apply to practice in a Catholic hospital," Msgr. O'Shea declared, "but he must practice medicine in accordance with his conscience. The conscience of a doctor as well as that of an individual is formed by the eternal word of God. Everyone knows where the hospital stands on the question of birth control. St. Francis Hospital has been, is, and always will be open to people of all races, colors, creeds. People who have donated funds to the hospital knew when they made their donations where the hospital stands on the question of birth control. I am certain that every doctor, every Christian, and every citizen will realize that on a question like this we cannot carry water on both shoulders."

Protestant clergymen in the community joined the planned parenthood league in protesting the hospital's action. "The attempt to police the thoughts and personal actions of individuals in our American democracy is un-American and contrary to our cherished principles," Rev. Philip A. Swartz of the First Congregational Church stated for the group.

"We affirm and support the high ethical principles of planned parenthood. The planned family is necessary for the well being of this and every other community throughout the world."

Several days after the doctors were asked to resign, the Planned Parenthood Federation of America, Inc., complained



Acme Photo

Three doctors involved in Poughkeepsie dispute are, l. to r.: Dr. Paul M. Lass, Dr. John F. Rogers and Dr. Martin Leiser.

to the New York State Commission Against Discrimination, claiming that the hospital's action constituted coercion of the physicians involved and was "an infringement of the freedom of Dutchess County citizens to receive medical advice on family planning." The federation also said the action was apparently in violation of state law forbidding discrimination against employees for race, creed, color or national origin solely on religious grounds.

Edward W. Edwards, chairman of the state commission, said the case would have to be studied to determine whether or not the law had been violated. The law requires that complaints be filed by an aggrieved person who charges he was discriminated against. Commissioner Edwards pointed out, whereas the complaint was filed by the federation and not by the physicians themselves. The commissioner also said there was doubt whether the physicians, who were hospital staff members, were employees within the meaning of the law.

The national Catholic weekly review, *America*, said in an editorial that protests against the hospital's action were

"the kind of furore to which Catholics are sadly becoming resigned."

"The hospital's stand is not a new departure in Catholic practice, nor is it a deviation from the standards of private institutions in general," the editorial stated. "The courts have always upheld the rights of private institutions to choose their own staffs, and the medical profession holds as a basic principle that a hospital administration is free to choose the type of doctor it wants."

"No one should be surprised any longer at the Catholic stand on birth control," the journal continued. "Medical men recognize and accept the fact that they are expected to abide by the rules of a Catholic hospital when they join its staff. The Poughkeepsie case, however, seems to demand of the doctors more than compliance with regulations inside the hospital. Those who have taken up the cudgels against St. Francis Hospital—most of them, apparently, not medical men—say that the hospital is trying to dictate the lives of its staff in their associations outside the hospital."

"First, it is worthy of note that all seven doctors are non-Catholics, chosen by the Sisters to serve their sick. These doctors had, and have, control over their own consciences and actions. But once they become affiliates of a Catholic hospital, certain of their public actions which touch upon medical ethics are of concern to the hospital."

Mount Sinai Hospital Observes Centennial Year

NEW YORK.—Mount Sinai Hospital of New York opened a year-long centennial celebration January 16 with a ceremony at the hospital.

At the opening ceremony, depicting the hospital's medical past and a forecast of its medical future, four student nurses donned crinoline period gowns to illustrate Mount Sinai's rôle in aiding women. In 1886 the hospital conferred a diploma on Dr. Josephine Walter, first woman in this country to serve a formal internship.

With a centennial banner as a backdrop, Alfred L. Rose, president of the hospital, Carl J. Austrian, a trustee serving as centennial chairman, and Dr. Martin R. Steinberg, hospital director, presented a centennial parchment scroll to the four costumed nurses and a candle was lighted on a three-tiered white birthday cake topped with a sugar reproduction of the hospital's first home.



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NEWS...

Dr. Rourke To Speak at Tri-State Assembly Banquet

CHICAGO.—Dr. Anthony J. J. Rourke of San Francisco, president of the American Hospital Association, will be the principal speaker during the twenty-second annual Tri-State Hospital Assembly in Chicago April 29, according to Dr. Malcolm T. MacEachern, chairman. Dr. Rourke will also preside at a forum on "The New Plan of Accreditation of Hospitals" on the opening evening of the assembly, with George Bugbee, executive director of the American Hospital Association, presenting the subject.

Speakers on the general theme, "Meeting the Challenge for Service," at the opening general assembly of Tri-State on Monday morning, April 28, will be Joseph G. Norby of Milwaukee who will discuss, "Quality of Service—What Are Its Ingredients?"; Ernest I. Erickson of Chicago, "Care for All Types of Patients—Is Integrated Community Planning Feasible?"; Roy Hudenberg of the American Hospital Association, "Hospital Responsibility for Patient Safety," and Anthony Eckert of Perth Amboy, N.J., "Hospital Responsibility to the Public in Emergencies—Industrial Disasters, Floods, Tornadoes, Wrecks, Civil Defense."

"Human Relations" will be the theme of the Tuesday morning general assembly. Among the speakers will be Dr. Kenneth Babcock of Detroit, and Dr. J. J. Moore of Chicago.

"Obtaining Adequate Nursing Personnel," a panel discussion, will be one of the subjects under the general theme, "Planning for the Future," at the Wednesday morning, April 30, general assembly. The moderator will be Marion Fox of Chicago, nursing specialist of the American Hospital Association, and the collaborators will be Dr. Theresa I. Lynch of Philadelphia on "Student Nurse Recruitment," Paul H. Keiser of Chicago on "Financing Cost of Nursing Education," and Marion J. Wright of Detroit on "What Can Be Done to Meet Today's Needs?" Also speaking at the Wednesday morning assembly will be Graham L. Davis of Chicago, director of the Commission on Financing Hospital Care, who will discuss "Costs in Line With Service—Can They Be Controlled?" The need for care of chronically ill, geriatric and polio patients in general hospitals will be discussed by a representative of the Commission on Chronic Illness.

A.H.A. CONFERENCE

(Continued From Page 150)

"problem areas" in hospital finance, including costs and factors affecting costs, utilization of hospital facilities, third party payments, and personnel and public relations. In the pilot study now under way in North Carolina, Mr. Davis said, an analysis of the demand for hospital facilities is being made. Following completion of this study, he said, a public relations and education program would be introduced to test various methods of changing public attitudes toward hospital care.

Dr. Anthony J. J. Rourke, A.H.A. president, reported to the group on hospital accreditation. The Joint Commission on Hospital Accreditation has appointed a special committee to select and recommend a director for the commission, he said. The committee was meeting during the coming week, he added. Explaining how the commission planned to operate, Dr. Rourke said hospitals would be selected for inspection by the executive director and an advisory committee from the commission; following this selection, hospitals will be assigned to the inspection staffs of the constituent organizations of the commission, it was explained.

When a hospital is not satisfied with action of the commission following an inspection, Dr. Rourke said, an appeal may be made to the commission itself. In such cases, inspectors working directly for the commission may visit the hospital, it was explained.

Speaking on the function of regional hospital associations, Kenneth F. Wallace of Oklahoma City, business manager at the University of Oklahoma Hospitals and president of the Mid-West Hospital Association, said a conference of regional hospital associations indicated that regional meetings should seek to interest hospital department heads and plan educational programs for departmental executives, in contrast to the national conventions, which are planned primarily for administrators. Mr. Wallace said state and regional hospital associations owed thanks to Blue Cross for the provision of secretarial and public relations services. He also acknowledged the help of the Hospital Industries' Association and its executive secretary, Edgerton Hart, in working out schedules of meetings to avoid conflict between educational sessions and time allotted for visiting exhibits.

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Standing: Daniel F. Mulvey, Robert B. Snook, James H. Fraser, Frank E. Slattery, Edwin E. Staudt, Brendan Sullivan, Robert M. Applewhite, Herbert Scholtz, William Morgan Welsh, Reynolds Johnson, Ernest S. Vena.

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NEWS...

Importance of Third Party Payments Stressed by Wisconsin Speakers

MILWAUKEE. — Approximately 400 hospital administrators, department heads, trustees and auxiliary members attended the annual conference of the Wisconsin Hospital Association here last month. The state hospital auxiliary group conducted its own meeting in connection with the conference.

The principal address at the opening meeting of the association was presented by Harry Becker, assistant director of the Commission on the Financing of Hospital Care and formerly social security director of the United Automobile Workers, C.I.O. Mr. Becker addressed the group on the significance of "third party payments" in the future development of hospital service.

Hospitals can expect further increases in operating costs, Mr. Becker said, along with a constantly rising demand for hospital services. Inevitably, he said, these demands would result in an ever-increasing number of third party payments. In the next 10 years, he predicted, the number of people covered by prepayment hospitalization plans would be doubled.



Dr. Harold D. Coon (left) presents the annual award of merit of the Wisconsin Hospital Association to Nels Hanshus, administrator, Lutheran Hospital, Eau Claire, and long-time executive secretary.

"This means that 90 per cent of hospital patients may have the major portion of their hospital bills paid by third parties," he concluded.

Mr. Becker said hospitals and Blue Cross plans should be able to work together successfully to increase the scope of plan benefits to a point where most of the hospital bill would be included in the coverage. Plans must also be expanded to include the aged, chronic disease patients, and indigent and unemployed persons, so that hospitals can

recover their full cost from such cases, he added, and eventually outpatient services must also be included in the prepayment schedules.

Following Mr. Becker's talk, Leon Wheeler, director of Wisconsin Blue Cross, said hospitals should accept their responsibility for educating medical staffs to reduce unnecessary admissions and services for Blue Cross patients.

Speaking for the insurance field, George H. Hipp, group department manager for the Employers' Mutual Insurance Company, asked for hospital cooperation with commercial insurance carriers. The insurance industry as a whole is sincerely trying to bring comprehensive hospital coverage to all the people, he said. The full success of voluntary health insurance depends primarily on the extension of prepayment medical care plans, he said. Mr. Hipp declared that charges for similar services should be "reasonably comparable" among hospitals in the same area and that the individual hospital should charge the same amount for the same service to all classes of patients. He seconded Mr. Wheeler's plea for hospital-doctor cooperation in curbing unnecessary admissions and services.

Continuing the third party discussion, Frank Carr, administrator of the Waukesha Memorial Hospital, stressed the importance of early diagnosis and treatment as the best ultimate method of reducing hospital cost to the community. Extension of outpatient services by hospitals to reduce admissions and length of stay will be necessary, Mr. Carr declared.

The public relations value of such enterprises as coffee shops and gift shops and volunteer activities far outweigh the financial advantage to the hospital, Mrs. A. E. Pinanski of Brookline, Mass., chairman of the A.H.A. committee on Women's Hospital Auxiliaries, told the Wisconsin group. The auxiliary can be a powerful aid in such activities as recruiting student nurses and making nursing life more attractive, Mrs. Pinanski said. Members of the women's auxiliary must obviously be thoroughly informed about the hospital and about hospital problems generally, she added.

The meeting ended with a round table discussion of current hospital problems led by Everett W. Jones, vice president of The Modern Hospital Publishing Company. Much of the discussion was devoted to details of the national hospital accreditation program. It was suggested that the program might benefit



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NEWS...

hospitals most if major emphasis were placed on medical audits and professional standards in the hospital rather than physical plant and administration.

Catholic Hospitals of Wisconsin Hold Meeting

MILWAUKEE.—Hospitals that ask manufacturers and suppliers to contribute to fund raising campaigns are doing an injustice to the entire hospital field, stated Everett W. Jones, vice president

of The Modern Hospital Publishing Company, at a conference of Wisconsin Catholic hospitals here last month. Mr. Jones differentiated between contributions sought from manufacturers by hospitals in their own communities and requests for donations from suppliers outside the community. Like other employers, the manufacturer of hospital supplies has a responsibility to the hospital which cares for its own employees, Mr. Jones said; however, hospitals seeking gifts from suppliers outside the community in return for purchases made

are engaging in a practice which "borders on blackjacking methods," he concluded.

In another address to the conference, which was devoted to "Human Relations in Hospital Service," the Rev. John J. Flanagan, executive director of the Catholic Hospital Association, urged Catholic nursing orders to "return to bedside nursing."

"By giving Sisters administrative duties and leaving bedside nursing to lay nurses, we are cutting our religious orders away from the sick," Father Flanagan said. "We criticize lay nurses for lack of nursing spirit, but we do not dignify this charge by doing nursing ourselves. This trend is affecting our patient care and our public relations." Father Flanagan recommended that Catholic Sisters should themselves perform nursing duties whenever possible and should employ administrative workers from the lay community.

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Contributions of Negroes in Mental Health Institutions Cited in Psychiatric Study

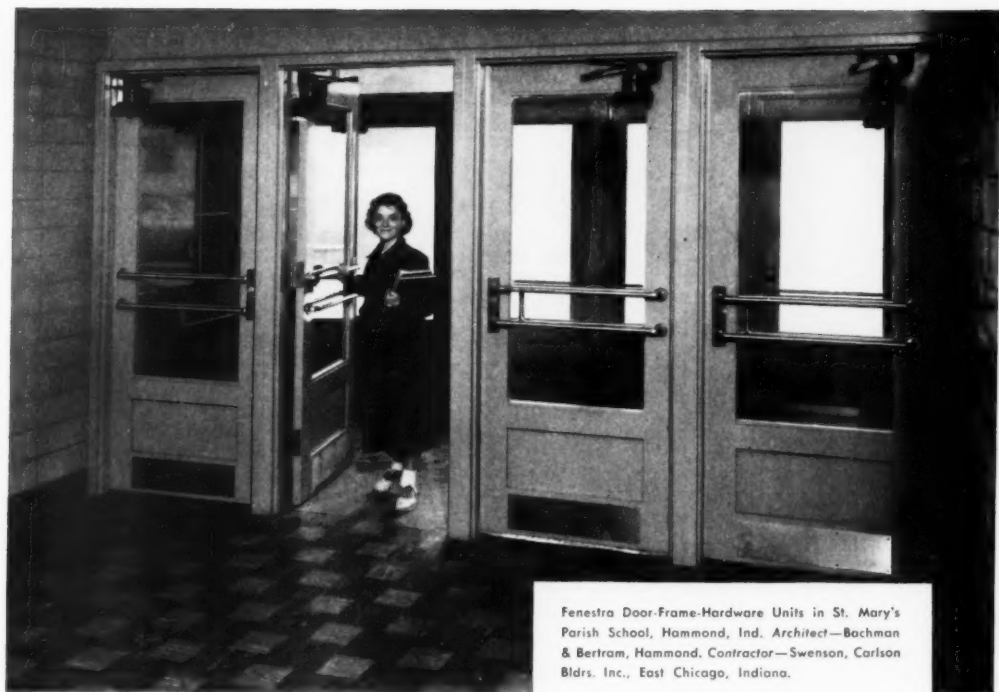
NEW YORK.—Negroes and whites can get along together in mental hospitals. This applies to both patients and hospital personnel, and it is true even when the people concerned come from the South and are used to segregation.

These are the views of Dr. Rutherford B. Stevens, a Howard University graduate and a practicing New York psychiatrist. He is the author of an article on "Interracial Practices in Mental Hospitals" appearing in the current issue of *Mental Hygiene*, a publication of the National Association for Mental Health.

Negroes can make a real contribution to mental health in this country, Dr. Stevens indicates. He says, "Negro attendants (in mental hospitals) have proved eminently satisfactory wherever their services have been utilized," and he suggests that the United States has in Negroes "an untapped reservoir of personnel, use of which should lessen the burden of caring for the mentally ill."

Dr. Stevens quotes several administrators of hospitals where there is no segregation. One says, "Our experience has been singularly painless in discouraging all discrimination as to race or color." Another says concerning use of Negro employees, "No difficulties have arisen among either the other employees or patients traceable to the factor of race."

(Continued on Page 160)



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NEWS...

Commenting on the fear of some administrators that using Negro help will cause "trouble" leading to the resignation of other employees, Dr. Stevens says the fear is proved unjustified by the fact that in other occupations, white employes have been found perfectly willing to work with Negroes.

Mentioned by Dr. Stevens is the example of military hospitals in the South and in border states during World War II. There was no discrimination in such hospitals, and no trouble, either, accord-

ing to Dr. Stevens. He mentions particularly Winter Veterans' Hospital in Topeka, Kan., where many whites and Negroes from the South were successfully treated together.

Of the use of Negroes as attendants, he says, "The fact that Negroes are at a disadvantage in obtaining work for which they are qualified encourages many with better-than-average education and training qualifications to accept these positions when available."

Few Negroes are trained as nurses or

psychiatrists, he notes. "About 20 of America's 5000 psychiatrists are Negroes. While the scarcity of Negro professional psychiatric personnel partly accounts for the very small number employed by mental institutions, it also points up the necessity of providing training for a greater number of those who are qualified," he says.

Dr. Stevens' article is based on a study made by the Committee on Social Issues of the Group for Advancement of Psychiatry. He is chairman of that committee. The study, covering 296 public and private institutions, shows that most public hospitals in the South segregate Negroes completely, that most in the North and West do not discriminate, and that segregation is common in border states.

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Presbyterian Hospital Shows Deficit of \$168,000 in 1951

NEW YORK.—A deficit of \$168,000 exists for 1951 in providing care for 32,636 inpatients and 380,445 outpatients at Presbyterian Hospital in the city of New York. Charles P. Cooper, president of the hospital, who cited the statistics, based his assertion on the annual report submitted recently to the hospital's board of trustees.

Ward patients received the equivalent of 71,417 days of care, and 102,519 clinic visits were made, both free of charge to the patients.

A total of \$13,549,000, or \$1,114,000 more than a year ago, was spent by the hospital to provide care for the inpatients and 380,445 visits were made to the outpatient department.

Linking voluntary hospitals with education, religious and charitable institutions where no one, no matter how much he pays, ever tenders full value for what he receives, Mr. Cooper reported that the cost for patient care in 1951 was \$5 greater per day than the average patient paid. Income from patients amounted to \$8,838,000, or about two-thirds of the total expense. To provide the remaining one-third, the hospital used \$2,245,000 of investment income from endowments, \$630,000 from gifts and contributions, and \$1,670,000 from other sources.

Touching upon medicine's conquest of shock, pain and infection Mr. Cooper pointed to the over-all advance in knowledge made possible by medical research in various fields.



*Above: St. Vincent's Hospital, N. Y., Main Floor Corridor—Allied E. Smith Memorial Building.
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NEWS...

New York's Blue Cross, Blue Shield Raise Rates

NEW YORK.—To meet increased hospital costs New York's Blue Cross plan, the Associated Hospital Service, will increase its subscription charges; and because of higher utilization, New York's Blue Shield plan, the United Medical Service, also will increase its group subscription rates for surgical and surgical-medical coverage, effective May 1, it has been announced.

New monthly rates for group mem-

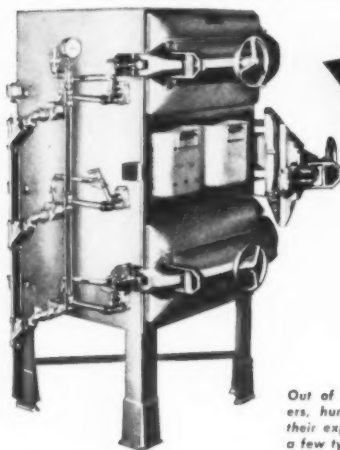
bership in A.H.S. are \$1.60 for an individual and \$4.36 for a husband and wife or a family. New rates for non-group membership, payable on a quarterly basis, are \$6 for an individual and \$15 for a family.

The new U.M.S. rates for surgical coverage are \$0.68 for an individual, \$1.60 for a husband and wife, and \$2.88 for a family. Rates for surgical-medical coverage will be \$0.88 for an individual, \$2 for a husband and wife, and \$3.40 for a family.

The Blue Cross insurance plan announced it had to dip into its reserves for \$1,735,713 to meet rising costs during 1951. Another \$4,000,000 of reserve funds will have to be spent before the increased rates go into effect, it was estimated.

Some 4,900,000 persons in the New York metropolitan area are enrolled in the two plans.

Louis H. Pink, head of Blue Cross, explained that federal law and state insurance department regulations require both plans to hold 5 per cent of their annual receipts in a reserve fund. Both plans have met rising costs by falling behind in—or dipping from—the reserve funds, he said.



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From a New Hampshire hospital: "The purchase of our steam cooker in the past summer now gives us two beautiful stainless metal STEAM-CHEF steam cookers. The first one was purchased about two years ago, and obviously the satisfaction we got from it determined our need and desire for a second one."

From an Ohio store restaurant manager: "I have had a lot of pleasure out of cooking with your fine piece of equipment and never would be without it. It has so many advantages over cooking over the top of the stove. It is much cleaner and faster in so many ways."

From an Oregon institution: "Our new kitchen is very modern but the cooks prize the STEAM-CHEF above all the other appliances. It surely shortens cooking time."

From a North Carolina institution: "The use of this piece of equipment helps greatly in reducing time of cooking. We are proud of it and have cooked our hams and dried beans in it very successfully."

From a South Dakota hospital: "We like our STEAM-CHEF very much and have found it very efficient this summer in canning hundreds of quarts of beans, tomatoes, vegetable pieces, etc., from our garden."

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John Bigelow Appointed Executive Secretary of Washington Association

SEATTLE.—The Washington State Hospital Association has announced the opening of offices here at 370 Skinner Building, and the appointment of John Bigelow as executive secretary.

Mr. Bigelow formerly was on the editorial staff of the *Seattle Times* where he was a medical and general staff writer. His background includes newspaper work in Spokane, Wash., and Salt Lake City, and public relations work in the Pacific Northwest and Washington, D.C.

Chester Finkbeiner, president of the association, said Mr. Bigelow's duties as executive secretary will be to work for better community relations of all hospitals, individually and as a group.

A.A.N.A. Passes New Accreditation Program

CHICAGO.—The American Association of Nurse Anesthetists' new accreditation program, which became effective January 19, requires schools established after that date to comply with the new requirements at the time of making application for approval.

Existing schools desiring full approval must conform to the new rules by Dec. 31, 1953.

The accepted criteria require that the course be of a year's duration and include 200 hours of classwork and 400 hours of clinical instruction. In addition, a school desiring approval must comply with the association's by-laws in selecting students, complete a questionnaire, and consent to inspection.

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**J. Pediat. 39:325, 1951*

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NEWS...

New York City Hospitals Set Record for Patient Care; Reduce Overcrowding

NEW YORK.—The Department of Hospitals here rendered more care to more people in 1951 than in any other year in its history and still effected a reduction in the overcrowding of its wards, according to the department's annual report.

A total of 279,093 inpatients received 7,935,952 days of care and 2,167,300 visits were recorded in outpatient services, in contrast to the 1950 figures of 277,821 inpatients receiving 7,761,732 days of care and 2,155,580 visits to outpatient departments.

The reduction of the average bed occupancy rate in the department was from 99.5 per cent in 1950 to 98.3 per cent for 1951.

Home care was the major factor in reducing ward congestion, the report stated. It rendered 664,698 days of care, or 8.4 per cent of the total days of inpatient care. Dr. Marcus D. Kogel, Commissioner of Hospitals, pointed out that home care, since its inception three years ago, has become the equivalent of a 2150 bed hospital operating at the normal bed occupancy rate of 85 per cent. Without home care, he said, the wards of the department's general hospitals would now be operating at an occupancy rate of 113 per cent.

Other factors which helped reduce overcrowding were: The providing of more extensive diagnostic facilities in outpatient departments so as to decrease the number of patients admitted to the wards for diagnostic study; and expansion of the physical medicine and rehabilitation service.

Two new hospitals, the 307 bed Francis Delafield Cancer Hospital and the 734 bed tuberculosis unit of Kings County Hospital Center, were opened during the year.

"The extreme difficulty in recruiting nursing personnel has made it necessary to open new hospitals on a ward-by-ward basis," Dr. Kogel said. "The Francis Delafield was opened with a bed complement of 39, roughly one-tenth its capacity. Its complement is now 156. The new tuberculosis unit at Kings County opened with a complement of 360 beds." He added: "It is a miserable condition indeed that sees unopened wards in magnificent new hospitals while older institutions operate at bed occupancy rates far above accepted standards."



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NEWS...

Urges Better Laws Governing Practical Nurses

NEW YORK.—An increasing number of hospitals are recognizing practical nurses as important partners on the nation's health team and are utilizing their services, according to a report released last month by Hilda M. Torrop, executive director of the National Association for Practical Nurse Education.

The association is urging enactment of stricter and more uniform state laws governing the field of practical nursing.

Miss Torrop, who believes that the public must be protected from the unqualified practitioner, stated: "In caring for helpless people, the practical nurse often deals with life and death situations; and so there can be no question of the necessity for establishing the highest possible standards in the field of practical nursing."

Only five states in the country and one United States territory, Hawaii, now have laws requiring practical nurses to obtain licenses before they can accept

employment, Miss Torrop reported after a survey of existing legislation. In 29 other states and in Puerto Rico, she pointed out, the law permits the practical nurse to work even if she fails to qualify for a license, while 14 states have no licensing laws at all.

Michigan's Nursing School Has New Four-Year Program

ANN ARBOR, MICH.—The University of Michigan School of Nursing has announced a new four-year basic professional program in nursing.

Rhoda Reddig, director of the school, explained that the new program will lead to the degree of bachelor of science in nursing for all graduates and will also qualify them for the state licensing examination.

Previously the school of nursing offered two programs. One required three years and led to a diploma in nursing; the other required five years and led to a college degree. Both programs will be replaced by the new one, although one more class will be admitted next September under the old five-year curriculum.

"Better nursing" is the aim of the new program, which is in line with a national trend in nursing education. The foundation of general education which is included in the revised curriculum is expected to prepare the nurse to understand the economic, social and emotional problems of patients as well as to assist the nurse herself in successful personal living.

Baptist Hospital to Celebrate 40th Anniversary

MEMPHIS, TENN.—Baptist Memorial Hospital here will celebrate its fortieth anniversary with a week-long program of events in July, announced Frank S. Groner, administrator of the hospital.

Beginning July 13, the observance will reach its climax July 20, the date upon which the institution first opened its doors to the people of Memphis and the surrounding area.

Tentative plans call for a series of "open houses" during which doctors, nurses and the general public from throughout the Mid-South area will be invited to tour and inspect the South's largest private hospital where more than 500 people are cared for daily, Mr. Groner explained.



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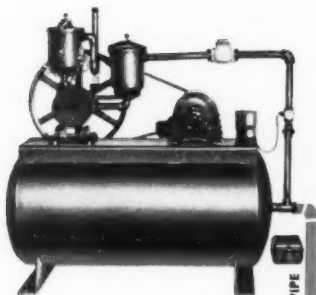
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NEWS...

Death Rates in U.S. Fall for Several Important Diseases

WASHINGTON, D.C. — Basing his comments on vital statistics compiled by the U.S. Public Health Service, Oscar R. Ewing, Federal Security Administrator, has announced that death rates in the United States fell significantly in 1950 compared with 1949 for several important diseases, including acute poliomyelitis, tuberculosis and measles.

The Public Health Service has released final 1949 death rates for 32 selected causes of death, and estimated 1950 rates based on a 10 per cent sample of death certificates.

The death rate for acute poliomyelitis, per 100,000 population, fell off by 39 per cent in 1950. In actual numbers there were 2720 polio deaths in 1949, and 1690 estimated for 1950. This is believed to parallel a drop in cases reported in 1950 compared with 1949. The tuberculosis death rate dropped 16 per cent for an estimated decrease of 5470 deaths. The death rate for measles was cut in half, coinciding with a decline in the number of cases of measles in 1950.

Other important causes of death with decreases in death rates were gastritis and some intestinal diseases, cirrhosis of the liver, complications of pregnancy, and homicide. The maternal death rate, per 10,000 live births, dropped from 9.0 in 1949 to an estimated rate of 7.2 in 1950, a record low.

Probably as a result of the influenza epidemic during the late winter and early spring months of 1950, death rates for influenza and pneumonia for 1950 increased slightly over 1949. There were an estimated 44,640 cases in 1949 as compared with 47,093 in 1950. The death rate for diseases of the heart also increased slightly, from 746,434 in 1949 to 770,699 in 1950. Cancer deaths remained at about the same level in both years.

Named Delegate to A.H.A.

JACKSON, MISS.—John Gill, business manager of Mercy Hospital-Street Memorial at Vicksburg, Miss., and R. M. Castle, administrator of Rush Memorial Hospital at Meridian, Miss., were chosen as the delegate and alternate, respectively, of the Mississippi State Hospital Association to the House of Delegates of the American Association at a special meeting February 5 at Jackson, Miss.

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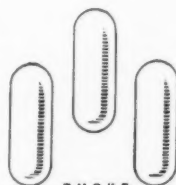
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NEWS...

Undertake Investigation of Kings County Hospital

NEW YORK.—Investigation of policies and practices at Kings County Hospital, Brooklyn, has been undertaken here by the Hospital Council of Greater New York at the request of the city's Board of Hospitals. The Kings County Hospital had been under attack for several weeks for overcrowding and understaffing, it was explained.

Dr. Haven Emerson, former health commissioner and professor of public health at Columbia University, was named director of the investigation, which will be supervised by a five member committee headed by John H. Hayes, superintendent of Lenox Hill Hospital.

Other members of the supervisory committee are: Msgr. Joseph E. Brophy, director, division of health, Catholic Charities of the Diocese of Brooklyn; Msgr. John J. Curry, director, division of health and hospitals, Catholic Charities of the Archdiocese of New York; Dr. J. J. Golub, executive vice president of the Hospital for Joint Diseases and former chairman of the hospital planning council of the American Hospital Association, and Mrs. Francisca K. Thomas, acting executive director of the hospital council.

Home Nursing Care Saves New York \$750,000

NEW YORK.—According to a report submitted by Patricia I. Heely, director of the New York City health department's bureau of public health nursing, New York's hospital department saved \$750,000 in Queens alone for the first nine months of 1951 by providing home nursing care for patients who otherwise might have required hospitalization.

In addition, 220 beds in Queens General and Triboro hospitals, that otherwise would have been required by chronic patients, were made available for acute cases.

Health department nurses made 11,147 visits to homes of patients under medical supervision of the two hospitals and she estimated that these patients would have spent a total of 68,676 days in one or the other institution without the home-care program. Miss Heely reported that the cost of this hospital care would have been \$801,684, in contrast to the actual cost of less than \$46,880.

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NEWS...

Voluntary Admissions Favored by Mental Hospitals, Council Report Reveals

NEW YORK.—A growing national trend in the field of emotional health is the use of voluntary commitments for mental hospitals.

Because preventive psychotherapy is eliminating the stigma surrounding mental hospitals, 10 states within the last 12 years have enacted laws for voluntary admissions and 40 states have laws providing for such commitments, although the actual use of such a law is limited in most states, according to a recent comprehensive report. The report, entitled "The Mental Health Programs of the Forty-Eight States," was prepared by Brevard E. Cribfield, director of research for the Council of State Governments. It states:

"Voluntary hospitalization saves time and money for the states and embarrassment for the patient and it tends to reduce length of stay in the hospital. Voluntary admission procedures should be provided in all states and should be used more extensively."

Four states, New Jersey, California, Illinois and Ohio, are among those in which voluntary commitments are high, the report showed.

"There is no question about the desirability of voluntary commitments," declared Dr. George S. Stevenson, medical director of the National Association for Mental Health. "If one thinks of the mental hospital as a kind of safeguarding of the public, then one depends entirely on court commitments, but if one thinks of it as a hospital to help ill people, one advocates voluntary commitments."

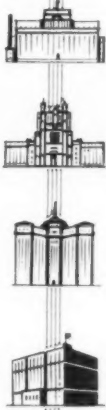
One difficulty which arises is that those who know they need help often cannot obtain the best treatment for it in state systems because many of them are set up to help only those who are very ill. Nevertheless, a short stay can be more beneficial than it is if the person who is brought in fights treatment, authorities explain.

According to the Council of State Governments' report, overcrowding is the most serious detriment to patient comfort and well-being. About 43 per cent of the mental hospitals replying to a questionnaire (representing 94 per cent of the nation's mental hospitals) reported overcrowding in excess of 20 per cent. Bryce Hospital, Tuscaloosa, Ala., had the most overcrowded conditions, 109 per cent over capacity.

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NEWS...

Montefiore Hospital Opens Expanded Dental Clinic

NEW YORK CITY.—A scientific symposium at Montefiore Hospital here on the cause and nature of dental caries also marked the opening of a new dental clinic at the hospital.

Two visiting British research investigators, Prof. Edgar B. Manley and Dr. J. L. Hardwick of the University of Birmingham and Birmingham Dental School in England, presented a paper on "Caries: A Physico-Chemical and Histological Approach." They declared that their investigations indicate that caries result from a combined action of chemical and bacterial factors on the organic structure of teeth. Their conclusions were largely based on evidence resulting from a newly developed microscopic technic of studying the histology of teeth, for which Professor Manley recently received the John Tomes Award, England's highest honor for dental research.

The new dental clinic, which will expand the dental department services inaugurated 30 years ago, is housed in an eight-room suite containing five mobile treatment chairs and units, a surgery room, a "recovery room," an x-ray department, and complete laboratory facilities.

A staff of four interns and 38 attending dentists will assist Dr. David Tanchester, chief of the dental department, in providing more than 7000 treatments a year to Montefiore's ward and clinic patients. The facilities are also available to those being cared for under Montefiore's home care and family health maintenance plans.

Canadian Hospital Exceeds Fund Goal by 15 per Cent

MONTREAL, CANADA.—The Royal Victoria Hospital Campaign Fund, which had as its original goal, \$7,000,000, has succeeded in going over the top by 15.5 per cent, or \$8,076,489.

The announcement, according to a report by Harold Crabtree, general chairman of the campaign, means that, despite increased building costs, the hospital can proceed with its initial modernization and expansion plans.

The fund raising campaign will serve to meet the minimum needs of the hospital, which are: (1) erection of a new \$4,000,000 nine-story building to be the center of surgical, laboratory and

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x-ray departments; (2) modernization and expansion of the outpatient department; (3) modernization of the administration building; (4) reorganization of the wards to provide 277 more semiprivate and public ward beds, and (5) building of a new 50 bed psychiatric wing for the Allan Memorial Institute.

Mr. Crabtree also stated that grants from government sources to date totaled \$2,400,000, made up of a grant from the province of Quebec of \$1,600,000 and a grant from the city of Montreal of \$800,000.

COMING MEETINGS

ALABAMA HOSPITAL ASSOCIATION, Russell Erskine Hotel, Huntsville, March 14, 15.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Shoreham Hotel, Washington, D.C., Oct. 13-17.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Fellows' Seminar, University of Michigan, Ann Arbor, Dec. 5-8.

AMERICAN HOSPITAL ASSOCIATION, Philadelphia, Sept. 15-18.

AMERICAN PHYSICAL THERAPY ASSOCIATION, Bellevue-Stratford Hotel, Philadelphia, June 23-28.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May 5-6.

ASSOCIATION OF WESTERN HOSPITALS, San Francisco, May 12-15.

BLUE CROSS-BLUE SHIELD ANNUAL CONFERENCE, Fairmont and Mark Hopkins hotels, San Francisco, March 31-April 3.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24-25.

CATHOLIC HOSPITAL ASSOCIATION, Cleveland, May 26-29.

CATHOLIC SCHOOLS OF NURSING, Public Auditorium, Cleveland, May 29, 30.

CONNECTICUT HOSPITAL ASSOCIATION, Auditorium, Southern New England Telephone Co., New Haven, May 20.

ILLINOIS HOSPITAL ASSOCIATION, Abraham Lincoln Hotel, Springfield, Nov. 20, 21.

INTERNATIONAL CONGRESS ON MEDICAL RECORDS, London, England, Sept. 7-12.

IOWA HOSPITAL ASSOCIATION, Kirkwood Hotel, Des Moines, April 23.

LOUISIANA HOSPITAL ASSOCIATION, Bentley Hotel, Alexandria, March 13, 14.

KENTUCKY HOSPITAL ASSOCIATION, Seebach Hotel, Louisville, March 25-27.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel du Pont, Wilmington, Del., Nov. 10, 11.

MICHIGAN HOSPITAL ASSOCIATION, Statler Hotel, Detroit, Nov. 9-11.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MID-WEST HOSPITAL ASSOCIATION, President Hotel and Municipal Auditorium, Kansas City, Mo., April 23-25.

MINNESOTA STATE MEDICAL ASSOCIATION, Minneapolis Auditorium, Minneapolis, May 26-28.

MISSISSIPPI HOSPITAL ASSOCIATION, Heidelberg Hotel, Jackson, Oct. 16, 17.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Rice Hotel, Houston, Tex., May 21-24.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, March 24-26.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 21-23.

NEW YORK STATE ASSOCIATION OF MEDICAL RECORDS LIBRARIANS, Hotel Syracuse, Syracuse, June 11-13.

NEW YORK STATE DIETETIC ASSOCIATION, Hotel Seneca, Rochester, April 24, 25.

NORTH DAKOTA HOSPITAL ASSOCIATION, Dakota Hotel, Grand Forks, April 1.

OHIO HOSPITAL ASSOCIATION, Cleveland Hotel, Cleveland, March 31-April 3.

RHODE ISLAND HOSPITAL ASSOCIATION, Miriam Hospital, Providence, Dec. 13.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta, Ga., April 14-18.

TENNESSEE HOSPITAL ASSOCIATION, Peabody Hotel, Memphis, May 8-10.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 20-22.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

UPPER MID-WEST HOSPITAL CONFERENCE, Lowry and St. Paul Hotels, St. Paul, May 14-16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Roanoke Hotel, Roanoke, April 24.

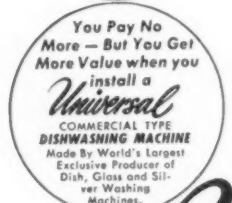
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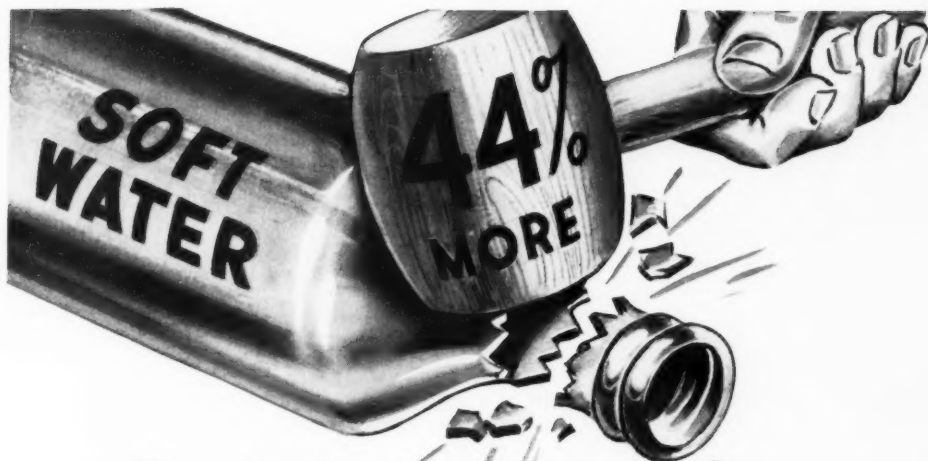


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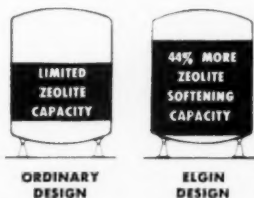
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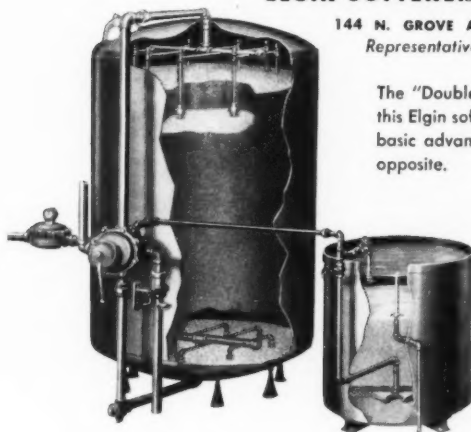
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NEWS...

Hospitals' Immunity From Liability Suits Vanishing, Chicago Attorney Declares

CHICAGO. — The so-called trust fund doctrine limiting the liability of charitable institutions, including hospitals, for negligence of employees is becoming a thing of the past, John D. DeFeo, a member of the Chicago law firm of Cassels, Potter and Bentley, declared here recently. Mr. DeFeo presented a paper on the subject "Tort Liability

of Charities" at a meeting of the Society of Trial Lawyers here. "It would appear that the qualified or limited liability rule will be a thing of the past, and that we are headed for unqualified liability," Mr. DeFeo concluded after reviewing a number of recent court decisions on the subject.

In a recent decision, the Illinois Supreme Court stated:

"We are of the opinion that the exemption or immunity which has been afforded a charitable institution should

go no further than to protect its trust funds from being taken to satisfy its liability for the tortious acts of its agents or servants," Mr. DeFeo reported. In a similar decision, the supreme court of Tennessee several years ago ruled that "exemption and protection afforded to a charitable institution is not immunity from suit, not nonliability for a tort, but the protection actually given to the trust funds themselves," the speaker added.

Mr. DeFeo said the doctrine of immunity of charitable trusts originated in the case of McDonald v. the Massachusetts General Hospital which was decided in 1876. After finding that the defendant was a public charitable institution, he reported, the court held that the institution was not liable in an action for injury for the negligence of its servant "where the charity has exercised due care in the selection of its agents."

Doctors Assist in Framing Policy at Jewish Hospital

GLEN OAKS, N.Y. — A number of doctors have accepted the invitation of the board of trustees of the proposed new Long Island Jewish Hospital here to offer advice and guidance on medical staff policy.

The hospital, to serve the Queens-Nassau-Suffolk area, is an affiliate of the Federation of Jewish Philanthropies of New York. It expects to draw most of the members of its medical staff and organization from the local area.

Among the medical authorities who have addressed the board of trustees are: Dr. Henry Feinberg, president of the Queens County Medical Society; Dr. Arthur Fischl, past president of the society; Dr. Morris Hinenberg, medical consultant to the Federation of Jewish Philanthropies and past executive director of the Jewish Hospital of Brooklyn, and Dr. Malcolm T. MacEachern of Chicago, director of professional relations of the American Hospital Association.

"Appointments," said Dr. MacEachern, "should not be limited to diplomats and fellows of boards." He recommended strongly that the board of trustees, after selecting a trustworthy basic medical staff for the hospital, work in close conjunction with the staff, seeking advice from it on new appointments and otherwise consulting with it whenever feasible.



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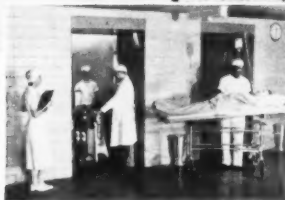


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NEWS...

N. Y. "Bulletin" Reviews Decline in Length of Stay Between 1940 and 1950

NEW YORK.—The Hospital Council of Greater New York reported in one of its recent bulletins that one of the major developments in hospital care in recent years is a decline in the length of stay of patients in general hospitals.

Chiefly responsible for this decline are medical advances, such as the antibiotic drugs, early ambulation after surgery and childbirth, and the prophylactic use of blood. The high birth rate of recent years, with resulting increase in demand for obstetrical beds, also has made for much earlier discharge of maternity patients.

COMPARES WITH U.S.

In New York City the decline in the average length of stay in general hospitals of all types was somewhat less than that reported by the *Journal of the American Medical Association* for the entire United States. The U.S. statistics showed a decline from 12.9 days in 1940 to 10 days in 1950, whereas in the city's general hospitals—municipal, voluntary and proprietary combined—the average length of stay declined from 13.2 days in 1940 to 11.8 days in 1950.

"At least part of the difference between the experience of the general hospitals in New York City and in the United States as a whole is accounted for by the high rate of occupancy in the municipal hospitals in this city and the larger number of patients with long-term illnesses accommodated by them," the *Bulletin* states.

"Furthermore, admissions to the general hospitals in New York City increased by 17 per cent between 1940 and 1950 while nationwide admissions increased 72 per cent. A higher rate of admissions is usually associated with a reduction in length of stay. Finally, New York City is known to be considerably closer to meeting total needs for general hospital beds than is the rest of the country, thus obviating the need to accelerate discharges for the purpose of increasing turnover of beds."

The average length of stay in voluntary general hospitals in New York City in 1950 was 10.5 days while for voluntary general hospitals throughout the country it was 8.1 days; patients in municipal general hospitals in the city remained an average of 16.8 days as against 12.6 days for all municipal general hospitals in the United States; and

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NEWS...

in the city's proprietary general hospitals the average stay was 7.4 days compared with 5.9 days for such institutions in the national picture.

General care patients discharged from voluntary hospitals remained an average of 10.9 days, from municipal hospitals 16.4 days, and from proprietary hospitals 6.6 days.

The longest average length of stay on general care services is in the municipal hospitals which are intended primarily for the medically indigent; the inter-

mediate length of stay is in the voluntary general hospitals where three types of patient accommodation—private, semiprivate and ward—are available; and the shortest average length of stay of general care patients was in the proprietary hospitals which serve patients who pay for their care.

In 1950, the average length of stay of general care patients in the various voluntary hospital accommodations were: private, 11.1 days; semiprivate, 9.3 days; and ward, 12.7 days.



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Need 60,000 Practical Nurses, According to Report of National Association

NEW YORK.—In a special report reviewing a decade of activities, the National Association for Practical Nurse Education urged the immediate training of 60,000 practical nurses to help ease the nation's serious nursing shortage.

"In the face of this need, there are now only 7000 students attending 180 accredited schools of practical nursing throughout the country," Hilda M. Torrop, executive director of the association, disclosed. "Although there has been a tremendous increase in the number of such schools in the last 10 years—an increase of more than 700 per cent since 1941—many more training centers must be established without delay."

Miss Torrop reported that the U.S. Office of Education today recognizes practical nursing as an important career for women. Training for this field is now included in its vocational education program. In addition, local boards of education all over the country also are including practical nurse training as part of their vocational programs.

The report estimated that there are now approximately 400,000 women employed as practical nurses in the United States. Of these, only a comparatively small proportion has had the benefit of training in an approved school, which generally takes about one year.

"This is due to the fact," Miss Torrop said, "that until the association started its campaign to raise the standards of practical nurse education, there was no agency, public or private, that passed on the competence of the schools or the teachers."

The association now makes periodic survey visits to schools on its approved lists to see that standards are maintained. It also helps new schools organize and acts as adviser to both private and governmental sponsors of practical nursing schools.

One of the most important gains cited in the review is that more states are becoming aware of the need for practical nurse legislation. Ten years ago, said Miss Torrop, "there was little control exercised by the various states. Now, every year, additional states are passing practical nurse licensing laws, and in the wake of these laws come higher standards for practical nurse training."

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ABOUT PEOPLE (Continued From Page 98)

trative internship with the Kellogg Foundation. He is a member of the American Hospital Association and a nominee of the American College of Hospital Administrators.

Jose A. Llavin, a 1947 graduate of the class in hospital administration at the School of Public Health, Columbia University has been made administrator of the San Juan City Hospital, San Juan, Puerto Rico. Mr. Llavin was formerly director of the Fajardo Charity District Hospital at Fajardo, Puerto Rico.

Leo J. Weaver has resigned as chief accountant at the Lewistown Hospital, Lewistown, Pa., to accept the post of administrator of the Adrian Hospital at Punxsutawney, Pa.

Rodney W. Hemsworth has been named administrator of Norways Foundation Hospital. He was administrative assistant of the general hospital division of the Medical Center at Jersey City, N.J., for three years, and previous to that he was with the University of Minnesota Hospitals for six years. Mr. Hemsworth, who received his master of hospital administration degree from the University of Minnesota, is a nominee of the American College of Hospital Administrators. He also is a hospital administrative officer in the U.S. Air Force Reserve.

Lucetta K. Rose has resigned as superintendent of Suburban General Hospital, Bellevue, Pa. Her successor in the superintendency is **John B. Mallon**.

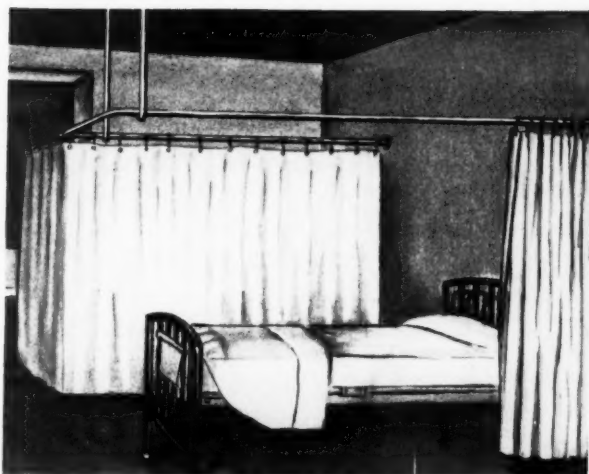
Dr. George O. Pratt, presently manager of the Veterans Administration Hospital at Manchester, N.H., has been appointed manager of the V.A. hospital in Brooklyn, N.Y. Dr. Pratt succeeds **Dr. Linus A. Zink**, whose transfer to the V.A.'s Mount Alto Hospital in Washington, D.C., was reported in the February issue of *The Modern Hospital*.

Donald A. Heron has been named business manager and assistant administrator of Holzer Hospital, Gallipolis, Ohio. He formerly was controller at Springfield City Hospital, Springfield, Ohio, and prior to that at Montefiore Hospital, Pittsburgh. Mr. Heron is a personal member of the American Hospital Association and a past president of the Southwestern Pennsylvania Accountants Association.

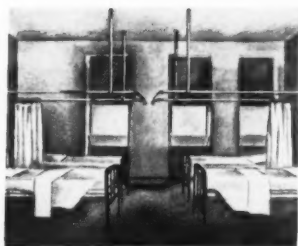
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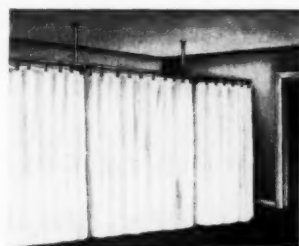
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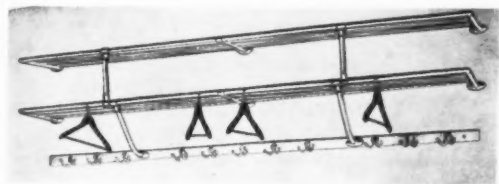
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Wrieden as administrator of the Salvation Army Door-of-Hope Home and Hospital at Jersey City, N.J. Major Kimball was transferred from a similar institution in Pittsburgh and Major Wrieden was transferred to the Booth Memorial Hospital in Cleveland.

Rhea C. Ackerman has been appointed assistant administrator of Morton Hospital, Taunton, Mass. From 1943 to 1950 Miss Ackerman was assistant administrator at Children's Hospital in Los Angeles.

Robert Haskins, who has been serving his administrative residency at Passavant

Memorial Hospital, Chicago, has been appointed assistant administrator of the Madison General Hospital, Madison, Wis. Prior to the beginning of his residency at Passavant last summer, Mr. Haskins completed the graduate program in hospital administration at Northwestern University and will receive his master's degree next June. He also is a graduate of the Alexian Brothers School of Nursing and served with the army medical corps in the Pacific theater from 1942 to 1946.

Dr. Kenneth W. Chapman has been appointed medical officer in charge of

the U.S. Public Health Service Hospital, Lexington, Ky. Dr. Chapman succeeds Dr. Victor H. Vogel, who now is assigned to the American Embassy in Paris, France, as medical officer in charge of the U.S. Public Health Service's foreign quarantine activities. In his new post, Dr. Chapman will be responsible for the management and operation of a 1400 bed hospital, the service's largest. Dr. Chapman, a psychiatrist, is a fellow of the American College of Physicians and a member of the American Psychiatric Association. He is certified by the American Board of Psychiatry.

Thomas J. Golden, administrative director of the Medical Center of Jersey City, N.J., retired February 1. Mr. Golden served as secretary of the New Jersey Hospital Association from 1927 to 1929 and then for 19 years, until 1948, as treasurer.

Samuel E. Stewart, who was formerly associated with the Chambersburg Hospital, Chambersburg, Pa., has been named administrator of the Muncy Valley Hospital, Muncy, Pa.

Ernest H. Stewart has been appointed administrator of the Sister Kenny Polio Hospital at El Monte, Calif. Mr. Stewart formerly operated five hospitals in Wyoming for the Lutheran Hospital and Homes Society. He is vice president of the Wyoming Hospital Association and a trustee of Blue Cross in that area. He also is a member of the American Hospital Association.

Sister M. Jeanette is the new administrator of St. Michael Hospital, Milwaukee.

Frederick C. Sage, formerly administrator of Concord Community Hospital, Concord, Calif., is now assistant administrator of the Methodist Hospital of Southern California, Los Angeles. Mr. Sage is a 1950 graduate of the class in hospital administration from Columbia University's School of Public Health.

Carl R. Baum, who has been associated with Children's Hospital of Buffalo, N.Y., as business manager since December 1948, has been named assistant director of the institution. Before joining the Children's Hospital staff Mr. Baum was office manager of the Hospital Service Corporation of Western New York.

Joseph A. Williamson has been appointed director of Hunterdon County Medical Center, Flemington, N.J. Following his graduation in 1949 from the class in hospital administration at Columbia University's School of Public Health, Mr. Williamson served as assist-



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ant director of Sharon General Hospital, Sharon, Pa.

Harold L. Slater has been named administrator of Lexington Community Hospital, Lexington, Neb., succeeding **V. A. Starr**, who relinquished the duties of administrator in order to devote full time as consultant for the hospital's modernization and expansion plan. Prior to this appointment, Mr. Starr served as administrator-consultant at Modoc Medical Center, Alturas, Calif.

Paul A. Smith, administrator of the Helena Hospital, Helena, Ark., for the last four years, has resigned to accept the post of administrator of the new 100 bed Navarro County Memorial Hospital at Corsicana, Tex., which has set its tentative opening date for June 1, 1952.

Mrs. A. J. Carlson has been named assistant superintendent of the Morris County Hospital, Council Grove, Kan.

Walter D. Golding has assumed his new duties as superintendent of Memorial Hospital at Colorado Springs, Colo. Mr. Golding, who was head of Buchanan Hospital at Lodi, Calif., for seven years, succeeds **Herman F. Zimoski**.

E. R. Andres has assumed his new duties as manager of Grandview Hospital, Edinburg, Tex., succeeding to the post made vacant by the death of **Vernon Watson**. Mr. Andres was associated with the Hillcrest Memorial Hospital and Nurses Training School, Tulsa, Okla., as assistant administrator and director of public relations from 1940 to 1942 when he entered the armed services and served in the medical administrative corps. In 1946 he returned to his former position at Hillcrest with the personnel department added to his duties. He then was appointed administrator of the Methodist State Hospital and Nurses Training School at Mitchell, S.D. In 1948 he became administrator of the Midland Memorial Hospital, Midland, Tex., a post from which he resigned to become associated with the Memorial Hospital of Martin County, Stanton, Tex. Mr. Andres is a nominee of the American College of Hospital Administrators.

Lynn Roberts has resigned as manager of the Pemiscot County Memorial Hospital at Hayti, Mo. **Frank Douglas** has been appointed to take over the management of the hospital.

R. M. Dearing has resigned as superintendent of Fostoria City Hospital, Fostoria, Ohio.

Ethel M. Sayre, who has been associated with Achenbach Memorial Hospital, Hardtner, Kan., for 10 years, has

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resigned her post as superintendent.

Walter Bahl has been named business manager for St. Catherine of Sienna Hospital at McCook, Neb., succeeding Frank Mulvey, who has accepted a similar post at St. Anthony Hospital, Denver.

Dr. Leland E. Stilwell has assumed his duties as manager of the new Veterans Administration Hospital at Iowa City, Iowa. Dr. Stilwell, who has been with the V.A. since 1946, is a graduate of the medical school at Columbia University. From 1933 to 1940 he was in private practice in Los Angeles, and was

on the faculty of the University of Southern California Medical School.

Thomas O. Bassett has retired as director of Dover General Hospital, Dover, N.J., a post he has held more than 20 years. Succeeding him in office is Charles T. Barker, who has been the assistant director at Dover for the last five years. Mr. Bassett is a member of the New Jersey Hospital Association's Council on Hospital Service Plans.

Thomas J. Finn has been appointed superintendent of the Berthold S. Pollak Hospital for Chest Diseases, Jersey City, N.J., and Dr. Benjamin P. Potter, who

has been associated with the institution since 1931, is medical director. Dr. Frederick J. Quigley is the former superintendent and medical director of the hospital. Mr. Finn has been with the New Jersey State Civil Service Department for the last 13 years and for the last six years has been concerned with job classification and evaluation in local government.

Edward J. Goodall has succeeded Stephen Pondak as administrator of Millville, N.J. Mr. Goodall formerly was the assistant superintendent of the General Hospital of Monroe County, East Stroudsburg, Pa.

Clarice H. McGarry, R.N., has been named administrator of the Valley Hospital, Ridgewood, N.J., where she has been assistant administrator since November. Mrs. McGarry's previous hospital connection was with the Lenox Hill Hospital in New York.

Frederick G. Whelply, assistant administrator of Evanston Hospital, Evanston, Ill., has been named administrator of Wyandotte General Hospital, Wyandotte, Mich. Mr. Whelply was named to his post in Evanston in July 1947, after being graduated in hospital administration from Northwestern University.

Henry Amicarella has been appointed to succeed Mr. Whelply at Evanston. He received his master's degree in hospital administration from Northwestern University. Mr. Amicarella was formerly executive assistant in the Veterans Administration Hospital, Fort Lyons, Colo.

Dr. Albert H. Fechner's appointment as manager of the Veterans Administration Neuropsychiatric Hospital, Salt Lake City, Utah, is one of four appointments announced recently by the V.A. The others are: Dr. Benjamin A. Cockrell as manager of the tuberculosis hospital at Memphis, Tenn., to succeed Dr. Glen W. Doolen, who is transferring to the central office in Washington, D.C.; Corydon F. Heard Jr. as assistant manager of the general medical and surgical hospital at Little Rock, Ark.; and Reed L. Clegg as assistant manager of the general medical and surgical hospital at Vancouver, Wash.

Eileen B. Callender has resigned her post as administrator of Alvin Memorial Hospital, Alvin, Tex., to accept the position of administrative assistant at Galveston County Memorial Hospital at La Marque, Tex. Before going to Alvin, Mrs. Callender was hospital relations director for the Texas Blue Cross plan.

John K. Lockhart, a recent graduate of the Duke University hospital administrative training program, is now ad-

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ministrator of the Roanoke Chowan Hospital, Ahoskie, N.C. Mr. Lockhart succeeds **Robert Gantt**, a 1949 graduate of the Duke program, who is now administrator of the Stanly County Memorial Hospital, Albermarle, N.C.

Department Heads

Gloria Powers has been appointed director of the newly organized personnel department at Mountainside Hospital, Montclair, N.J. Prior to her appointment at Mountainside, Mrs. Powers was personnel director at Harper Hospital, Detroit, where she organized the department. She also served as chairman of the personnel committee for the Detroit Area Hospital Council.

Dr. Robert Austin Grugan was named radiologist-in-chief at Springfield Hospital, Springfield, Mass., January 1. At the time of his appointment Dr. Grugan was a senior resident and assistant in radiology at the New England Deaconess Hospital, Boston. He is certified by the American Board of Radiology in full radiology, which includes all of the branches in the field.

Allen Farley is the newly appointed purchasing and personnel director at Sioux Valley Hospital, Sioux Falls, S.D.

Cmdr. Allen Franklin Bigelow, M.S.C., (U.S.N., Ret.) the senior officer of the medical service corps until his retirement, has been appointed director of the program analysis staff of the Veterans Administration department of medicine and surgery. As director of the program analysis staff, Commander Bigelow directs the activities of the administrative management division, the budget and planning division, the medical statistics division, and the liaison division of the department of medicine and surgery.

Nadyne Slater, R.N., is the new superintendent of nurses at Lexington Community Hospital, Lexington, Neb. Mrs. Slater is a graduate of Broadlawns County Hospital School of Nursing, Des Moines, Iowa. **Doris Hudson, R.N.,** has been appointed assistant superintendent of nurses at Lexington. Mrs. Hudson is a graduate of the Presbyterian School of Nursing, Denver.

Chloe Robinson has accepted the post of chief administrative dietitian of the Galveston County Memorial Hospital at La Marque, Tex. Miss Robinson formerly was in Memphis, Tenn.

Mary E. Eichelberger has been named personnel director of Evanston Hospital, Evanston, Ill. She formerly held the same position at San Joaquin General Hospital, Stockton, Calif.



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Dorothy L. Chionsini has accepted the post of accountant at the Galveston County Memorial Hospital, La Marque, Tex. Mrs. Chionsini formerly was employed in the accounting department of the John Sealy Hospital of the University of Texas School of Medicine, Galveston.

Miscellaneous

Joseph P. Peters has been assigned to the Division of Administrative Management, Bureau of Medical Services, U.S. Public Health Service, Washington, D.C. Mr. Peters is a graduate of the 1947 class

in hospital administration from Columbia University's School of Public Health and formerly was associated with the U.S. Marine Hospital, Detroit.

Grant H. Adams, for the last five years public relations director of Michael Reese Hospital, Chicago, has resigned. Previously Mr. Adams served five years as an administrative officer with the army air force.

Marvin W. Hinson, formerly administrator of Good Samaritan Hospital, Charlotte, N.C., has been appointed as an associate of **Harold J. Mayers**, hospital consultant, in the Washington, D.C.,

office of the United Mine Workers of America Welfare and Retirement Fund. He will develop liaison with the various hospitals which serve the beneficiaries of the fund.

Isabelle Godek is the new assistant professor in the School of Nursing Education at St. John's University, Brooklyn, N.Y.

Dr. George Marshall Lyon, founder and director of the radioisotope program in Veterans Administration hospitals, has been named assistant chief medical director for research and education succeeding **Dr. E. H. Cushing**, who is resigning, effective March 1. Dr. Lyon formerly was senior research assistant to Dr. Cushing.

Mabel McGuire Whittaker, R.N., has retired as director of medical social service in the Department of Hospitals of New York City, a post she has held for 12 years. Mrs. Whittaker entered the municipal hospital system in 1927 when she joined the social service staff of Metropolitan Hospital on Welfare Island. She became supervisor of social service at Metropolitan in 1930 and remained in that post until 1940 when she was brought to the central office. She was a member of the army nurse corps in World War I and also has worked in the public health field.

A. F. Wasson, former administrator of Perry Memorial Hospital, Perry, Okla., has been appointed a member of the New Mexico Hospital Advisory Council. Mr. Wasson is the former administrator of the Oklahoma Baptist Hospital, Muskogee, Miami Baptist Hospital, Miami, Southwest Baptist Hospital, Mangum, and Choctaw County Memorial Hospital, Hugo, all located in Oklahoma.

Deaths

A. Fraser Moffatt, treasurer of Ottawa Civic Hospital, Ottawa, Ont., and a member of the Ontario Hospital Association's board of directors, died December 16. Mr. Moffatt was first chairman of the association's accounting section and contributed much to the organization of the Accounting Institutes held in 1950. He also was second vice president of the American Association of Hospital Accountants.

Dr. John L. Ernst, superintendent of the Evangelical Deaconess Hospital, Detroit, died in December. Dr. Ernst was a past president of the Michigan Hospital Association, vice president of the American Protestant Hospital Association, past president of the Greater Detroit Area Hospital Council, a member



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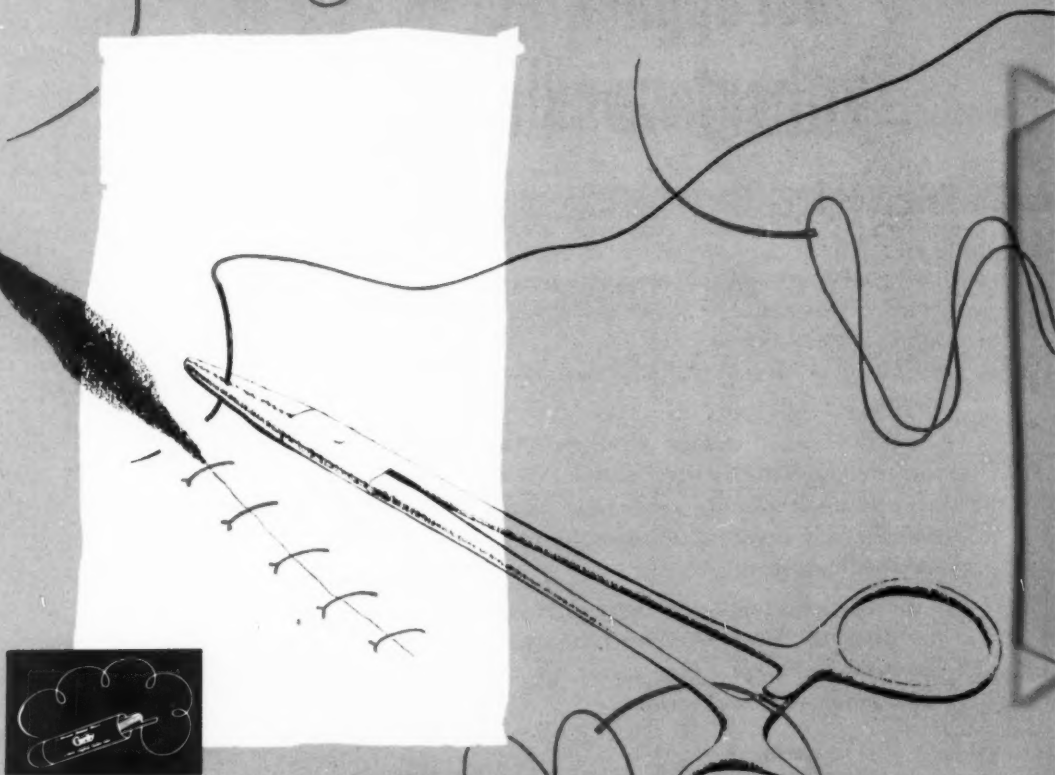
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No. 900. For "warmth without weight" and really rugged strength. Although this blanket is 50% wool and 50% cotton by weight, its nap is over 85% wool.

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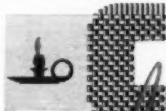
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of the executive committee of the state board of the Michigan Hospital Service, and a member of the American College of Hospital Administrators.

Dr. W. Jeff Anderson, owner and op-

erator of the Anderson Infirmary, Meridian, Miss., and a member of the 50 year club and charter member of the American Academy of General Practice in Mississippi, died recently.

Vote Three to Two for Semiprivate Rooms

CHICAGO. — Queried by an inquiring reporter for the Chicago *Sun-Times*, five persons voted three to two in favor of semiprivate as opposed to private hospital accommodations here last month. The question asked was: "If

you were hospitalized would you prefer to have a room to yourself or to share it with another?"

Listed as reasons by those who said they would prefer to share their hospital room with someone else were the fact that "it would make the time pass much faster." "I would like the conver-

sation." "When you have others around to talk to and entertain you, it takes your mind off your own troubles." "I'd not like being alone so much when I was sick; it's best to have someone around to talk with and keep one's mind occupied."

Of the three persons who favored shared accommodations, two indicated they had never been hospital patients.

Those who voted for private rooms gave the following reasons:

"I would definitely prefer to have my own room. When I want to read I can have the light on; when I want to sleep, I can have the light off. The same goes for the radio. If I have a roommate, I must always be considering him. You are uncomfortable enough without the problem of a shared room."

"Absolutely a room of my own. A year ago I was in the hospital for an operation. First few days, I had a private room. Then the nurses decided I'd be lonely and put me in a double room. They moved me in with an old man who was very sick. Just watching his pain and discomfort depressed me."



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Documentary Film Describes Ambulance Team at Work

CHICAGO. — An RKO-Pathé documentary short subject, "Ambulance Doctor," now being released for showing at theaters throughout the country, describes how skillful, emergency treatment at the scene of an accident or disaster helps save lives.

Produced by Jay Bonafield as one of the studios' "This Is America" series, the picture runs about 15 minutes.

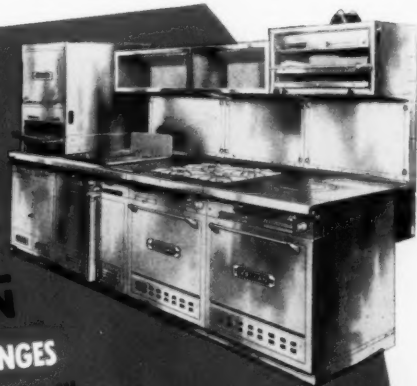
Filmed at the Roosevelt Hospital in New York City, "Ambulance Doctor" tells the story of the ambulance team—"three-man crew of medicine's shock troops"—and its experiences in a typical day speeding through the city traffic in answer to emergency calls. The film points out that some hospitals with ambulance teams answer as many as 10,000 emergency calls in a year, in addition to treating another 35,000 people in the hospital emergency wards.

The narrator explains early in the film that all hospitals do not have ambulance service, and the practice of having an intern or doctor accompany the ambulance team is not countrywide. The fact is also emphasized that where an intern or doctor does not ride in the ambulance, the "team," nonetheless, consists of well trained aides, skilled in the technics of first aid.

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Announce New TB Award

NEW YORK.—An annual award to be given to the person contributing most to tuberculosis control outside the field of medicine was announced here last month by the National Tuberculosis Association. The award will be presented in honor of the late Will Ross of Milwaukee, founder of Will Ross, Inc., hospital supply firm.

The first award of the Ross Medal will be made at the association's annual meeting at Boston next May, Dr. Alden S. Pope, N.T.A. president announced.

THE BOOKSHELF

HOSPITAL FIRE SAFETY. *Second Edition, 1951, National Fire Protection Association Book Report No. 104.*

A comparison of the first edition of this report with this second edition shows that three important new things have been added.

The new chapter giving the results of the fire inspection, sponsored by the National Fire Protection Association and the American Hospital Association, of all hospitals in Missouri is an important addition to the literature. Hospitals everywhere would do well to check up on their own hospitals and compare hazards found with those listed and classified in the Missouri hospitals inspection.

The new code for oxygen piping systems in hospitals has been reproduced completely in this new edition, and the revised operating room safety precautions and standards have also been included.

The addition of these three new things makes the second edition of this fire safety book "must" reading for all hospital administrators and their key department heads.—E. W. JONES.

MEDICAL TERMINOLOGY MADE EASY. By JeHarned, R.N., R.R.L., Chicago: Physicians' Record Company, 1951.

There is a constantly enlarging group of nonprofessional people surrounding the field of medicine to whom the language of the doctor is of great importance.

Mrs. JeHarned's book is a logical presentation of medical terminology. The appreciation of medical terminology depends upon the understanding of the precise meaning of medical words, the spelling of these words, and their pronunciation. Although medical language is largely derived from the Latin and Greek, it is nevertheless ever-changing, owing to the combination of old word stems, prefixes, and suffixes in new connotations. Added to this are sprinklings from many other languages which occur with discovery of new procedures and new drugs.

Word building can be better understood by the student who uses this material as a reference. Students of medical record science, x-ray students, student nurses, laboratory technicians, and other hospital personnel may extend their vocabulary by using it in close conjunction with a medical dictionary. In addition, schools of hospital administration will find this text a useful addition to their courses of study.—ROBERT F. BROWN, M.D.

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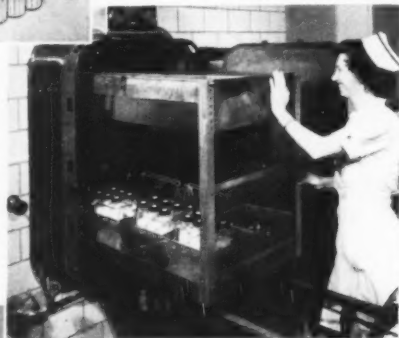
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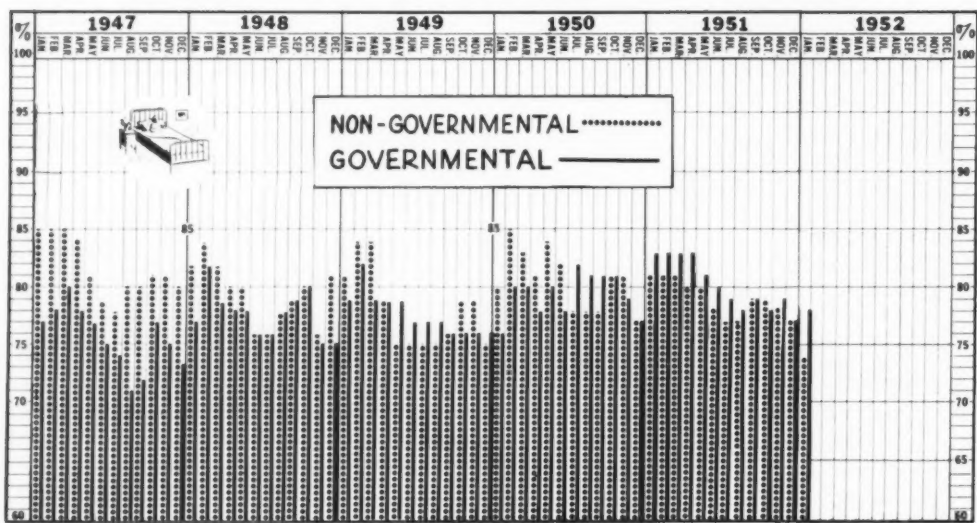
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Hospital Construction Totals \$67,198,908



Nongovernmental hospitals reporting to the Occupancy Chart for January 1952 were 74.3 per cent of capacity—below the levels of occupancy for the month of December 1951, and also lower than the figure for January last year. Gov-

ernmental hospitals reported January 1952 occupancy at 77.8 per cent, representing a slight increase over the previous month.

New hospital construction reported for the first two periods of the new

year totaled \$67,198,908—only slightly below the 1951 total for the same period. The total for the current year includes 24 new hospitals costing approximately \$19,000,000 and 49 additions costing \$40,000,000.



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The Medical Bureau

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ADMINISTRATOR—Medical; M.B.A., Hospital Administration; several years, assistant administrator, university hospital; eight years, director, voluntary hospital, 300 beds; FACHA.

ANESTHESIOLOGIST—Diplomate, American Board; eight years, private practice and on faculty medical school; four years, director, anesthesiology, fairly large hospital.

COMPTROLLER—R.S., Business Administration; four years' experience public accounting; seven years, supervisor, accounting department, 400-bed hospital.

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PATHOLOGIST—Diplomate; FCAP; two years, associate pathologist, large teaching hospital; four years, director of laboratories, 300-bed general hospital; in thirties; military exempt.

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(Continued on page 202)

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ANESTHETIST—Nurse; approved general hospital of 200 beds, New York suburban area; salary open. Apply, Albert J. O'Brien, Executive Director, Lawrence Hospital, Bronxville, New York.

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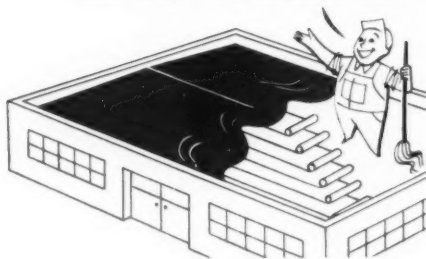
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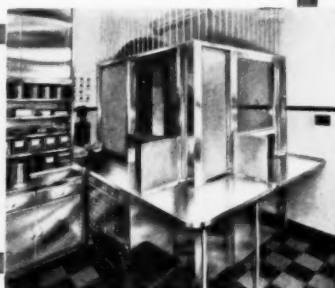
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DIETITIAN—To head department; 200-bed tuberculosis hospital; salary \$3800 and up, depending on qualifications and experience. Apply to, Superintendent, Sunshine Sanatorium, 700 Fuller, N.E., Grand Rapids, Michigan.

DIETITIAN—Assistant; ADA or equivalent; fully approved 80-bed general hospital; Pacific Northwest; salary open. MO 66, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR OF NURSES—Assistant; for 442-bed institution located in Delaware; Degree in Nursing Education required; salary depends upon qualifications and experience of the applicant; maintenance and apartment included. Apply to Director, School of Nursing, Delaware Hospital, Wilmington, Delaware.

DIRECTOR OF NURSES—Assistant; for a general hospital, fully approved; 44-hour week, 4 weeks' vacation, 7 paid holidays, sick leave; social security and insurance coverage; B. S. Degree in Nursing Education preferred; experience in nursing supervision or administration; salary open. Apply to Personnel Director, Franklin Square Hospital, Baltimore 23, Maryland.

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(Continued on page 204)

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DIRECTOR—Personnel; 320-bed hospital; experience in hospital personnel work desired. The Toledo Hospital, North Cove Boulevard, Toledo 6, Ohio.

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HOUSEKEEPER—Executive; fully approved 80-bed general hospital; Pacific Northwest; salary open. MO 67, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; for 442-bed institution located in Delaware; student body of 165; Degree in Nursing Education required; salary depends upon qualifications of the applicant. Apply to Director, School of Nursing, Delaware Hospital, Wilmington, Delaware.

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MISCELLANEOUS—Qualified Anesthetist; also, qualified Pediatric nurse; 125-bed approved hospital. Apply, Sacred Heart Hospital, Havre, Montana.

MISCELLANEOUS—General duty nurses; Ohio; 50-bed general hospital; 8 hours, 6-day week; six paid holidays; two weeks' vacation with pay; sick leave granted; starting salary \$200 per month with maintenance; also, 3-11 and 11-7 and operating Supervisors. Apply, Superintendent, Bellevue Hospital, Bellevue, Ohio.

MISCELLANEOUS—Matron and General duty nurse, both nurses with missionary interest; for 25-bed United Church hospital on British Columbia coast; urgent. Write for particulars, Medical Superintendent, General Hospital, Bella Coola, British Columbia, Canada.

MISCELLANEOUS—Operating room supervisor, immediate opening; good location; state capital with many civic advantages; salary open; Educational director also needed; degree required. Apply, Director of Nurses, Bismarck Evangelical Hospital, Bismarck, North Dakota.

MISCELLANEOUS—Podiatric clinical supervisor and instructor; also, Biological sciences instructor; degree preferable; salary open; personnel policies discussed with applicants. Apply, Director of Nurses, St. Mary's General Hospital, Lewiston, Maine.

(Continued on page 206)

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*Cerebral Palsy Hospital *Mt. Sinai Hospital
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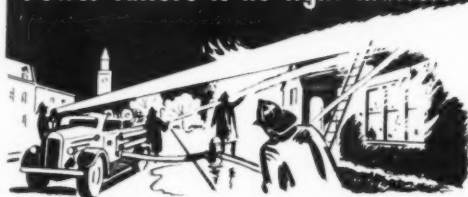
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3-1/2 oz. sherbet

NEW heavy glass base

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YOU ASKED US FOR THEM and here they are—brand-new sherbets in the 3½-oz. and 4½-oz. sizes.

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POSITIONS OPEN

NURSE—General floor supervisor for 34-bed hospital; salary open. Reed City Hospital, Reed City, Michigan.

NURSE—Head, operating room; 50-bed, fully approved general hospital; shift, 3 P.M. to 11 P.M.; active department; salary open. MO 79, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSE—Registered; for general duty; meals while on duty and laundry of uniforms. Apply, Business Manager, Lockney General Hospital, Lockney, Texas.

NURSE—Registered; general duty; \$231 month; single; 40-hour week; 3 weeks' vacation; United States citizens only. Write full particulars, Air Mail Special, to Personnel, Los Alamos Medical Center, Los Alamos, New Mexico.

NURSES—Salary above C.S.N.A. wage schedule; annual leave; sick leave; 11 holidays; 40-hour week. Apply, Administrator, Municipal Hospital, 316 South Floral Street, Visalia, California.

NURSES—General duty; new 50-bed general hospital in beautiful Valley of Virginia, county seat town; \$210 per month for 44-hour week, \$10 differential for 3 to 11; 11 to 7 shifts. Shenandoah County Memorial Hospital, Woodstock, Virginia.

NURSE—Registered; with operating room experience, wishing to learn matronship and be able to take over matron's position in near future; matron's salary, \$290 per month with increases; applicants must have had at least 3-5 years nursing experience. Apply, Herbert-Morse Union Hospital, Herbert, Saskatchewan, Canada.

NURSES—General duty; for 360-bed general hospital; starting salary \$175 per month with maintenance; \$290 per month with partial maintenance; rotating shifts; two weeks' vacation; 30 days' sick leave; 6 holidays yearly with pay; 44-hour week; college courses available through night classes at local university. Apply Director of Nursing, Greenville General Hospital, Greenville, South Carolina.

NURSES—General duty; for 275-bed Chicago teaching hospital; salary \$267 per month for P.M. duty; \$262 for night duty; \$247 for day duty; \$19 per month salary increases at 6 to 12 months and thereafter on merit; above salaries based on alternate 5- and 6-day week, average 44 hours; optional 40-hour week available when staffing completed; two weeks' vacation, 12 days' sick leave, pension plan, social security; 3½-room apartments in building overlooking Lake Michigan for \$35 per month per nurse, two nurses to an apartment; meals, \$10 per month for one meal per day, \$29 for two meals per day; Northwestern University affiliation with opportunity to take courses at half tuition. Write or apply, Personnel Department, Passavant Memorial Hospital, 303 East Superior Street, Chicago 11, Illinois.


NURSES—Graduate; general staff, in all departments; surgical scrub and obstetrical in 160-bed hospital; \$235 monthly with year end raises; 44-hour week and \$10 differential for evening or night shifts; 12 days sick leave, two weeks vacation. Apply, Mrs. Ruth Garland, R. N., Superintendent of Nurses, Memorial Hospital of Natrona County, Casper, Wyoming.

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains, 8-hour day, six-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary \$290 to \$210 month; full maintenance available for \$10.50 week. Apply Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary \$250 per month if applicant has advanced preparation or experience; \$10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Psychiatric; men and women; for general duty positions open in a psychiatric wing of a 750-bed hospital. Write, Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

(Continued on page 208)



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If YOU'VE had trouble with waxed floors that become slippery with use, you will be interested in the results of the test Mr. Van Krohn made with new Anti-Slip Cosmolite Wax. His hospital used to avoid wax because of the slip hazard . . . now he uses Cosmolite "with utmost confidence", and the floors are protected against both wear and weather!

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Cosmolite Wax assures a non-slippery surface and long life even under heavy traffic conditions. The surface remained bright and beautiful without rewaxing.

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NURSES—Registered; eight; starting salary equivalent to California State Nursing Association standards; comfortable modern nurses' home available; \$10 per month; after 1 year, 15 working days' vacation; cafeteria service; cumulative sick leave; 11 holidays yearly; rotation shift if desired; vacancies all nursing services, surgery nurse and obstetrical nurse supervisory. Apply, Director of Nurses, Tulare County General Hospital, Tulare, California.

NURSES—Registered; Hermann Hospital in the Texas Medical Center offers you unlimited opportunities; positions with pleasant working conditions are available now. Write, Director of Nurses, Hermann Hospital, Houston, Texas.

NURSES—Registered; for staff duty, 44-hour week, mealtime included; \$18.5, maintenance, without room; \$150, complete maintenance; increase \$60 annually after six months, one, two, and three years; \$5 extra for evening and night; \$10 for operating room. Episcopal Eye, Ear and Throat Hospital, Washington 5, District of Columbia.

NURSES—General staff; must rotate or be willing to work permanent afternoon or night duty; 40-hour week, liberal personnel policies; \$20 month afternoon or night bonus. Write Director of Nurses, Jewish Hospital, Cincinnati 29, Ohio.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary \$225; \$5 per month tenure increase for each six months of service to a maximum of \$255; two meals daily; social security, sick leave, prepaid medical and hospital care; \$10 additional for afternoon and night duty; \$15 additional for delivery room; \$20 additional for surgery; up to three weeks' vacation at end of 5 years; 6 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—General staff; surgical scrub nurses; minimum salary, basic \$240, 40-hour week, per policy. MO 71, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

NURSES—Staff; for 50-bed hospital. Apply, Administrator, Delaware Valley Hospital, Walton, New York.

NURSES—Staff; for a general hospital on medical, surgical and obstetric services; also vacancies on operating room staff; good personnel policies. Apply to Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—Staff and operating room; 5 days, 40 hours, 8 holidays and vacation with pay; initial salary, \$230 plus laundry; increases at 6, 12 and 24 months; additional pay for evening and night assignments and for operating room calls. Apply, Director of Nursing, St. Luke's Hospital, New York 25, New York.

RESIDENTS—One resident Physician, \$225 per month; two rotating Interns, \$150 per month; 117-bed general hospital, newly opened; appointments will be available July 1, 1952. Apply in writing, Administrator, Louise Obici Memorial Hospital, Suffolk, Virginia.

SOCIAL WORKER—Staff position; co-ordinate six hospital tuberculosis program medical-social work; experienced; preferred age 25 to 40; salary, \$3840, annual increments, travel expenses. Apply, State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

SOCIAL WORKERS—Medical-social work for 100-bed tuberculosis hospital; experienced; preferred age 25 to 40; salary \$3360, annual increments, travel expense. Apply, State Tuberculosis Hospital Commission, New State Office Building, Frankfort, Kentucky.

SUPERVISOR—For department of forty beds, medical and surgical patients; 150-bed general hospital with school of nursing; nurses' aides; salary depends on ability and experience; southeastern Ohio. Apply, Ruth Brant, Administrator, Martins Ferry Hospital, Martins Ferry, Ohio.

SUPERVISOR—In-service training; to develop program for registered nurses and non-professional employees for 140-bed general hospital; 40-hour week and liberal personnel policies. Write, Personnel Officer, St. Luke's Hospital, St. Paul, Minnesota.

(Continued on page 210)

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The diaper that does away with half the work in your laundry and nursery

BECAUSE

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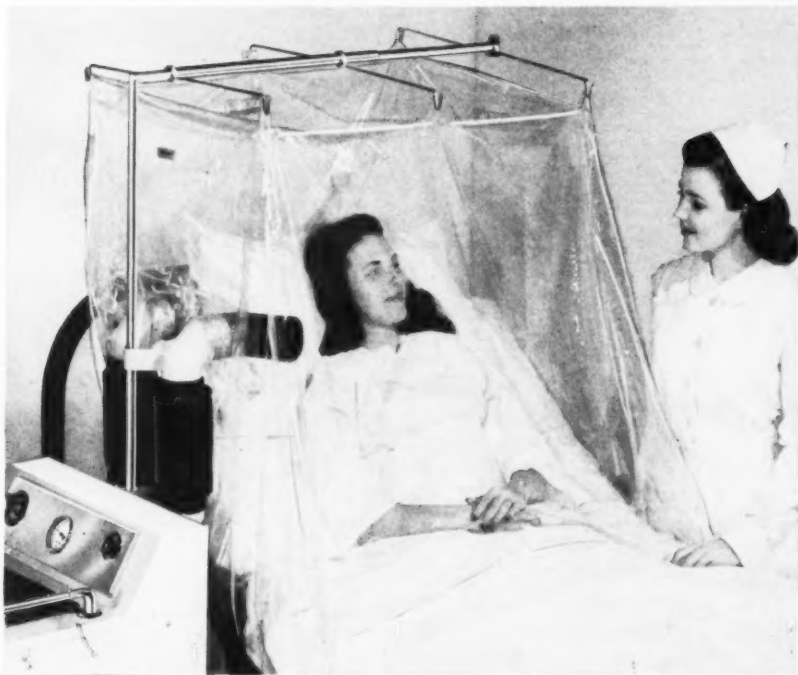
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canopies, quicker than ever before. As a result of our tremendous buying and production power, we can offer all Continental made canopies at NEW LOW PRICES.

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Wire or write for prices.

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POSITIONS OPEN

SUPERVISOR Operating room; for 345-bed hospital with expansion program; 44-hour week, no Sunday work; living accommodations, if desired; liberal personnel policies affecting vacation and sick leave; experience and advanced preparation required; person with degree will be given preference; salary open. MO 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR Operating room; fully approved 80-bed general hospital; very active department, all graduate nursing staff; salary open. MO 68, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR Operating room; for 100-bed general hospital, located in southwest Virginia; excellent working and living conditions; salary open. Apply, Superintendent of Nurses, Pulaski Hospital, Pulaski, Virginia.

SUPERVISOR Operating room; 600-bed hospital with active surgical service; staff consists of assistants, general duty graduates, students and auxiliary personnel; salary depends on experience and qualifications; excellent personnel policies. For further information write, Director of Nursing, Victoria Hospital, London, Ontario, Canada.

SUPERVISOR Assistant, operating room; fully approved 50-bed general hospital; very active department, graduate nursing staff; salary open. MO 69, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR Pediatric; for 442-bed institution located in Delaware; student body of 165; applicant must have a degree in nursing education, or be working for a degree; salary depends upon qualifications of the applicant. Apply to Director, School of Nursing, Delaware Hospital, Wilmington, Delaware.

TECHNICIAN Laboratory; registered, experienced; to head department under certified pathologist; for an immediate opening of Ottumwa Hospital; this is a 177-bed general hospital just completed, in a city of 40,000 population; salary \$300. Inquire in care of Dr. C. R. Phelps, Post Office Box 608, Ottumwa, Iowa.



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WOODWARD—Continued

general hospital; newly created post; hospital now expanding; beautiful resort town of Florida. (e) Lay; assistant; 250-bed, fully approved, general, voluntary hospital; very attractive town 50,000; northeast. (f) Lay; 200-bed general hospital ready fall of 1952; require administrator in near future; large California city. (g) Lay; 200-bed Evangelical hospital; central. (h) Lay; very large general hospital delightfully situated in Hawaii. (i) Lay; 175-bed general hospital; excellent nurses' training school; "sunshine" city of 100,000 delightfully situated on Mexican gulf. (j) 60-bed general hospital formerly owned by large industrial company; now has been turned over to non-profit organization; newly created post; town 10,000; north central. (k) Lay; 80-bed general hospital; new wing to be completed this summer will double size; debt free; fine town 20,000; east central. (l) Lay; 140-bed general, voluntary hospital; requires two years' experience hospitals similar size; university city 400,000; north central. (m) Lay; new general hospital now under construction; 125 beds; exceptionally fine county seat town 10,000; central.

ADMINISTRATIVE STAFF APPOINTMENTS

(a) Business manager; 350-bed university teaching hospital; university, medical center, metropolis. (b) Credit and collection manager; university teaching hospital; east. (c) Business manager-chief accountant; brand new 140-bed clinic-hospital; important AEC medical center; west. (d) Comptroller; entire charge financial department; hospital experience required; 500-bed general hospital; town 100,000; east.

(Continued on page 212)

Precision FOR INCISION

As the "Master Blade" for the Master Hand, where the need is for PRECISION, every Crescent Blade is precision-made for fine balance . . . precision-honed for extreme sharpness . . . precision-tested for strength and rigidity.

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This private room has draperies and cubicle of Goodall "Maidenhair" printed casement cloth...bedspread and slipcovers of "Chateau" fabric.



Goodall "Attica" drapery fabric is used as a handsome background for St. Vincent's smartly functional reception desk.

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Goodall "Haida" drapery fabric adds luxury, softens the sounds of voices and clattering china in this St. Vincent dining room.



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POSITIONS OPEN

WOODWARD—Continued

ADMINISTRATORS—NURSES. (a) 30-bed modern Florida hospital vicinity Daytona Beach. (b) 50-bed Class A hospital, well equipped and staffed; resort city 5000 and college town, north central location; \$5000. (c) 40-bed new hospital vicinity St. Louis; \$5400. (d) 60-bed approved hospital, city 10,000 northwest Michigan. (e) 30-bed hospital and clinic, prosperous community ninety miles from Chicago. (f) 80-bed tuberculosis hospital, New York mountain resort area. (g) 50-bed tuberculosis hospital, city 10,000, near Peoria, Illinois.

ANESTHESIA. (a) 80-bed general hospital, ocean resort community, southern Georgia; \$4800, maintenance. (b) 120-bed general hospital, Chicago suburb and college town; \$1800, maintenance. (c) New, modern general hospital, college town vicinity Springfield, Illinois; unusually attractive percentage arrangement. (d) 200-bed modern hospital, city 40,000, beautiful Potomac river valley; \$4800, maintenance. (e) Private anesthetist wanted for two surgeons, southern city 35,000; good hours, excellent salary. (f) New Hill Burton hospital, city 25,000, southeast Mississippi; \$5400.

DIETITIANS. (a) Modern 100-bed hospital, prosperous community northern California, excellent dietary department; \$4200 minimum. (b) Large, modern teaching hospital, Atlantic

WOODWARD—Continued

coast resort city; \$6000. (c) New 300-bed general hospital, eastern college town; salary open. (d) Large teaching hospital, east central city, 500,000; \$5000, maintenance.

DIRECTOR OF NURSES. (a) 100-bed modern hospital, pleasant community, eastern Arizona. (b) Large teaching hospital, excellent southern California location; degree and experience required; to \$5600. (c) 80-bed general hospital, California city 10,000, vicinity state capital; degrees, experience desired; excellent salary. (d) Associate director; 200-bed hospital, Colorado resort city; 40-hour week, \$3600 up. (e) Small general hospital, southwestern Florida; good salary plus maintenance. (f) 80-bed Illinois hospital with approved school of nursing; to \$5400, maintenance.

FACULTY APPOINTMENTS. (a) Assistant director, southern college of nursing; \$5000. (b) Director of nursing education; large eastern psychiatric hospital; \$4500 up. (c) Instructor medical-surgical nursing; 180-bed teaching hospital, western university city; \$3600 minimum. (d) Clinical instructor, medical-surgical department, midwest college of nursing; \$5000. (e) Nursing arts instructor; 125-bed Pennsylvania hospital; \$3600, maintenance, 40-hour week, excellent personnel policies. (f) Science instructor; 300-bed Pennsylvania hospital; good salary. (g) Psychiatric instructor; large eastern hospital; to \$4200. (h) Social science instructor; 200-bed hospital, east central city; good salary and maintenance.

WOODWARD—Continued

MALE NURSES. (a) New tuberculosis hospital, prosperous Illinois city 12,000; \$3600-\$4200, excellent working conditions. (b) Office assistant, excellent Chicago location; \$3600.

PHARMACISTS. (a) Large general hospital, southern California college town; \$4800. (b) 250-bed hospital, midwest university city 50,000; to \$5400. (c) 200-bed hospital, city 50,000, Chicago area; 40-hour week, good salary.

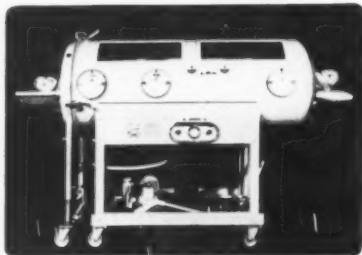
HOUSEKEEPERS. (a) 75-bed general hospital, Los Angeles area; salary open. (b) 200-bed general hospital, Rio Grande vicinity; salary open. (c) New 360-bed eastern hospital, university town; salary good. (d) 100-bed New Jersey hospital, city 40,000; \$250, complete maintenance. (e) 200-bed general hospital, expansion program completed this year; Pennsylvania; salary plus maintenance. (f) 225-bed general hospital, Chicago area; salary open.

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Philadelphia 43, Pennsylvania

CHIEF OF INDUSTRIAL HEALTH RESEARCH. With training and experience in toxicology, clinical psychology, and industrial health; M.D. not required; starting salary \$10,000, or better.

(Continued on page 214)



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NOW WITH

- Trendelenberg position
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tilts
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Two new features make the Toland

Stretcher even more versatile than before: (1) You can now obtain the Toland Stretcher designed for Trendelenberg Position and it's easy to set too! Just turn the crank, and the stretcher top rises smoothly, thru a gear mechanism. It's safe, positive and quick! No fussing with pins or bolts, no danger of slipping or jarring the patient. (2) Side Rails are now obtainable, making the Toland Stretcher ideal for post-operative use. Easily detached, and carried under the Stretcher.

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TOLAND HOSPITAL EQUIPMENT
BENTON HARBOR, MICHIGAN



"Sure, it will have a 'new look' outside— but it's really old-fashioned!"

What does he mean? Listen:

"Unless we install Honeywell Individual Room Temperature Control, our new hospital will actually be old-fashioned before we open the doors. I say we can't afford to be without it, for these new estimates show it will cost only ½ to 1% of our total expenditure to install this modern system."

Strong words? Not a bit. And here's the reason.

Today, in many hospitals, it is already routine medical practice to give each patient the exact room temperature he needs to speed his convalescence. This "prescription" can be filled only if every room has its own thermostat. No other

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Since that is true, it's just smart business to install individual room temperature controls *when your hospital is being built*. Doing it later, as a modernization project, is sure to cost substantially more money.

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*Only thermostat specially
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Honeywell's new Hospital Thermostat is the only thermostat to offer the special features needed for maximum hospital efficiency:

- "Nite-glowing dials" permit inspection without disturbing patients.
- Magnified numerals make readings easy to see.
- New speed-set control knob is camouflaged against tampering.

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First in Controls



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BUSINESS MANAGER—Large mental hospital; \$3600 to \$4800, plus family maintenance.

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DIRECTOR OF NURSING 140-bed hospital; starting \$5000 plus complete maintenance.

EXECUTIVE HOUSEKEEPER 375-bed hospital; salary open.

RECORD LIBRARIAN Chief; 250-bed hospital; large eastern city; start \$300 plus meals.

PHARMACIST Male or female; large mental hospital; \$400 plus full maintenance.

X-RAY TECHNICIAN Male or female; 190-bed hospital; New Jersey; attractive salary.

LABORATORY TECHNICIAN Chief; 150-bed hospital; well staffed department; starting \$300 plus lunch.

No charge for registration



The Medical Bureau

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CHICAGO

ADMINISTRATORS (a) Medical or lay administrator, with degree, to direct group of hospitals having capacity of several thousand; minimum ten years' administrative experience required; \$14,000-\$16,000, residence, all utilities. (b) Physician to serve as assistant to vice-president of medical college and assistant director of its teaching hospital. (c) General hospital currently under construction; will open in 1953 with 100 beds with ultimate expansion to 350; Pacific coast. (d) Consultant, hospital and medical services; organization comprised of more than million workers; experience with medical care programs advantageous. (e) Voluntary general hospital, fairly large size; university center; New England. (f) Administrator of outstanding qualifications; voluntary general hospital, 700 beds; expansion program; metropolitan area of the East. (g) New general hospital, 125 beds; midwestern town, 15,000, near university center. (h) Assistant; 700-bed hospital; expansion program will increase to 1200; opportunity excellent experience; university medical center; west. (i) Administrative assistant; general hospital 300 beds; early promotion to assistant directorship; east. MH3-1

MEDICAL BUREAU—Continued

ADMINISTRATORS REGISTERED NURSES, (a) Voluntary general hospital, 225 beds; town, 100,000, east; formal training, considerable experience desired. (b) New hospital, small size; rural area; west. MH3-2

ANESTHETISTS (a) Association with group of medical anesthesiologists; university center. (b) Relatively new hospital, 240 beds; department directed by Board anesthesiologist; three nurse anesthetists; 300 anesthetics monthly; \$5160 increasing to \$6350; attractive location. (c) Two, qualified to train nurse anesthetists; leading hospital, large city, foreign country. MH3-3

COLLEGE STUDENT HEALTH (a) Director, health program, liberal arts college; small town, near university center; midwest. (b) Social, health and recreational director; 250-bed hospital; college town, east. (c) Supervisor, student health program; large general hospital; Pacific coast. MH3-4

DIETITIANS (a) Chief; one of country's most important hospitals; teaching affiliations; \$6000-\$7000, maintenance included. (b) Head departments, hospitals of foreign operations, large industrial company; \$665 which includes living allowance of \$210. (c) Therapeutic and administrative dietitians; 200-bed hospital affiliated with group of distinguished specialists, on faculty medical school; 40-hour week; attractive city, south. (d) Nutrition consultant; public health agency; Chicago area. MH3-5

(Continued on page 216)



MAGGI'S SEASONING

Simply add a few dashes to your soups, stews, gravies, vegetables, and meats. Presto! . . . it brings out all the subtle hidden flavors and you have a dish fit for a king.

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10 oz. capacity
VB 8390

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Beverage Server, hot beverages *stay* hot to the last delicious sip. And, this genuine *Thermal Server* costs no more than an ordinary pot, and soon pays for itself by reducing breakage and replacements. It's sturdy and long lasting. However, if through abuse, the inside plastic filler has to be replaced, "it's as simple as changing a light bulb," and almost as inexpensive.

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POSITIONS OPEN

MEDICAL BUREAU—Continued

DIRECTORS OF NURSING AND SCHOOLS

(a) Dean, collegiate school; minimum Master's Degree required; should be qualified to reorganize department; present enrollment 325; three-year and five-year programs; around \$6000. (b) Director school of nursing; voluntary general hospital, 450 beds; college affiliations; duties with school only; large city, university medical center; west. (c) Beautiful new hospital, 350 beds, 125 students; town, 100,000, east; minimum \$7000. (d) General hospital; present capacity 300 beds; building program will increase to 500; collegiate affiliations; university town, south. (e) General hospital, 300 beds; winter resort city; Gulf coast; minimum, \$6000. MH3-6

DIRECTORS OF NURSING SERVICE (a) Group of hospitals including new general hospital, 200 beds, currently under construction; M.S. Degree desirable; Pacific coast. (b) Small general hospital operated by American company in South America. (c) University hospital, 600 beds; minimum \$5000, maintenance. (d) New tuberculosis sanatorium, 500 beds, unit university group; large city, important teaching center. (e) General hospital, 175 beds, recently completed; town, 25,000, resort area, Pacific Northwest. (f) Associate director; large teaching hospital; university center, east. MH3-7

MEDICAL BUREAU—Continued

EXECUTIVE HOUSEKEEPER—Man or woman; voluntary general hospital, 600 beds; teaching affiliations; expansion program; outstanding opportunity. MH3-12

EXECUTIVE PERSONNEL—(a) Business manager; background in accounting desirable; fairly large hospital; California. (b) Personnel director, qualified to establish and conduct department, 250-bed hospital; west. (c) Comptroller; should be qualified to assume administrative responsibilities; 350-bed hospital; east; \$5000-\$7000. (d) Credit and collection manager; teaching hospital, 400 beds; east. (e) Head admitting office, 350-bed hospital; medical school affiliations; east. MH3-8

FACULTY APPOINTMENTS—(a) Assistant professor in nursing service administration qualified develop new curriculum in nursing service administration and also, assistant professors or instructors in tuberculosis nursing and surgical specialties; university college of medicine. (b) Assistant professor in public health nursing; program recently established by eastern university. (c) Educational director; general hospital; seaport, resort town; West Indies. (d) Educational director and instructor of nursing; large general hospital, northern California. MH3-9

MEDICAL RECORD LIBRARIANS—(a) Head department, voluntary, general hospital, 500 beds; staff of five; minimum \$350; eastern metropolis. (b) Chief, record librarian; brand

MEDICAL BUREAU—Continued

new hospital, 600 beds, affiliated university medical school; west. (c) To take charge of department, group staffed by twenty specialists, Diplomates or eligible; college and health resort town, Rocky Mountain state. (d) Assistant medical record librarian; 700-bed teaching hospital; staff of 35; university medical center; east; minimum \$300. MH3-10

SUPERVISORS—(a) Medical and surgical; private and semi-private; 250-bed hospital; college town, east; opportunity continuing studies. (b) Operating room; large teaching hospital; staff, 16 nurses, 8 aides; \$5000. (c) Orthopedic; well staffed department; attractive location; California. (d) Pediatric and psychiatric; teaching hospital; south. (e) Obstetrical, pediatric and psychiatric supervisors; beautiful new institution completely air-conditioned throughout; 300 beds; affiliated university medical school; large city, west. MH3-11

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ADMINISTRATOR—Middle west; 250-bed hospital affiliated with medical school of world famous university; this is a splendid opportunity for an administrator with progressive ideas of hospital administration; \$15,000.

(Continued on page 218)

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TRAY COVERS**




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ROLLING SMOOTHLY!**

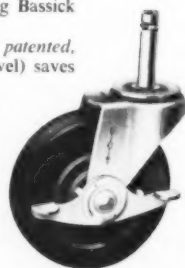


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Dial soap protects your patients, too!

DIAL bath and toilet soap also contains Hexachlorophene—so it will keep your patients' skin remarkably clear of bacteria that often aggravate and spread pimples, surface blemishes, etc. And still it is as mild as the finest complexion soaps. Yet DIAL *costs no more* than ordinary soaps. Give your patients Hexachlorophene protection—use DIAL!

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SHAY—Continued

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DIETITIANS—(a) Administrative; 300-bed teaching hospital; \$400, maintenance. (b) Therapeutic; \$250-\$300.

(Continued on page 220)

INTERSTATE—Continued

RECORD LIBRARIANS—(a) East. (b) Midwest. (c) South.

EXECUTIVE HOUSEKEEPERS—(a) 350-bed hospital, Ohio; university city. (b) 150-bed hospital, New York. (c) 200-bed hospitals; south, southwest.

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(Continued on page 222)

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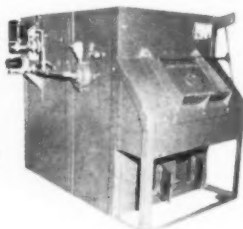
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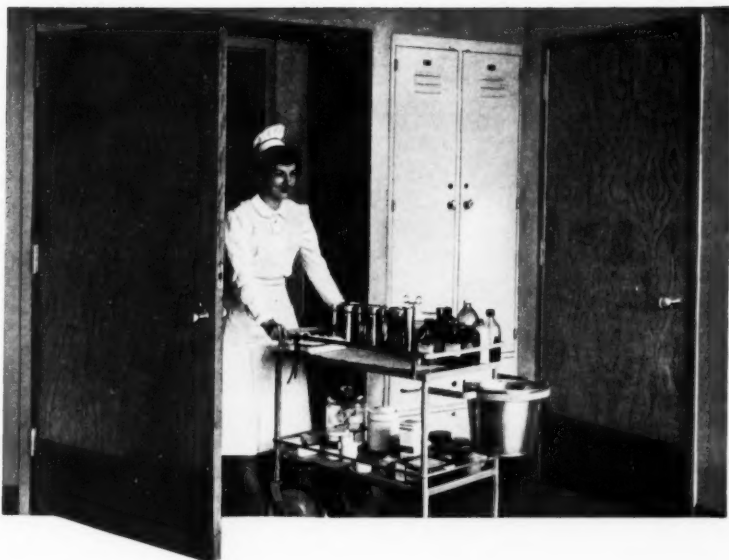
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(Continued on page 224)



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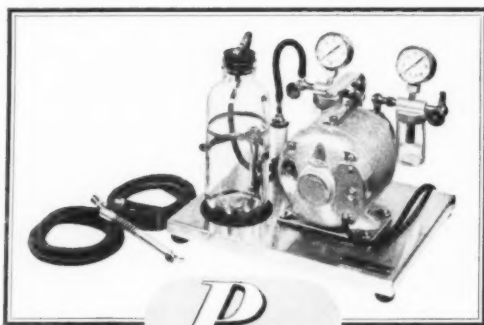
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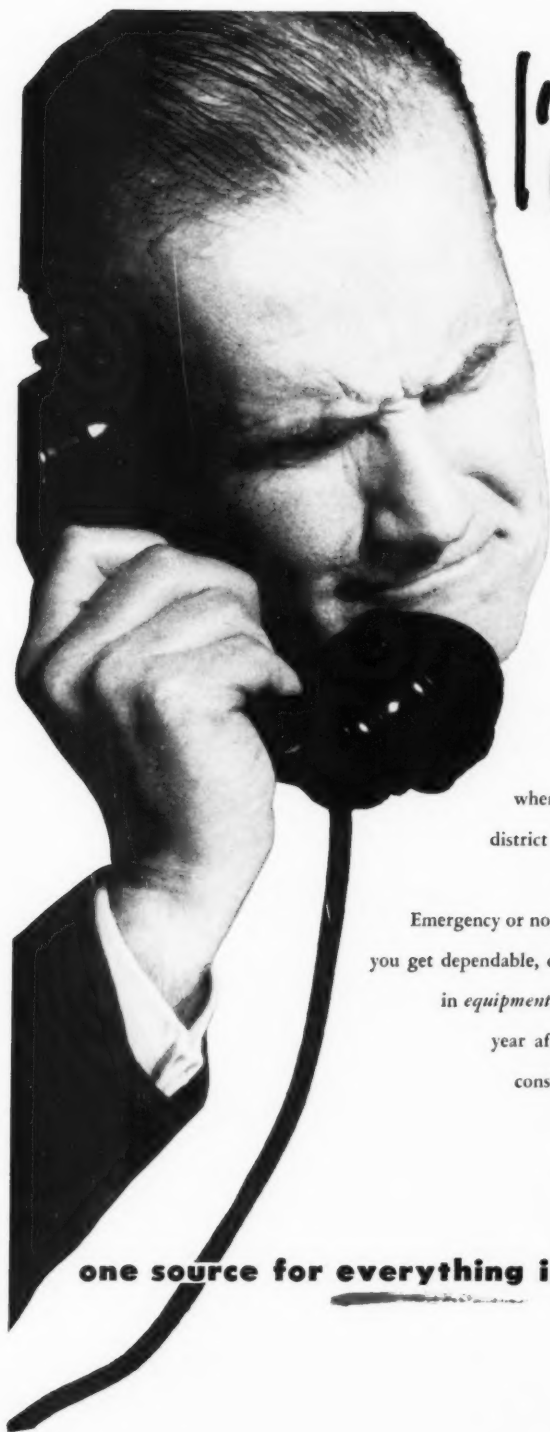
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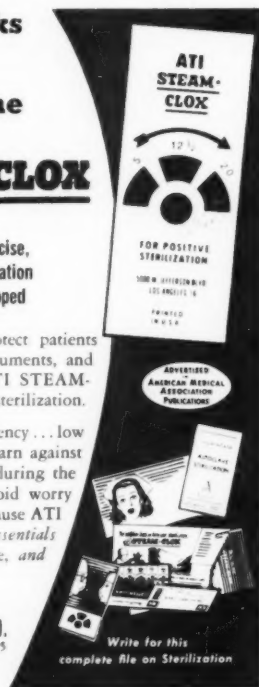
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Dependability is the watchword of America's hospitals. Edwards contributes generously to that dependability.



Edwards "Soft Speaking" Nurses' Call Systems assure prompt, step-saving attention to patients' needs at all times. Crystal-clear in tone yet so sensitive they transmit the weakest voice, these dependable systems operate on standard accessories. No special wiring needed.

Edwards Clock and Program Controls synchronized to incoming alternate current, enable one or a hundred clocks to keep perfect time together. No master clock needed.

Edwards Paging Systems, "the eyes and ears" of a hospital keep vital personnel within easy reach and call . . . page as many as 120 doctors, three at one time!



Protecting life and property throughout, dependable fool-proof Edwards Fire Alarms are functional as they are smart with their snug, wall-hugging compactness.

For further information, write Dept. M-3, The Edwards Company, Inc., Norwalk, Conn.

What's New for Hospitals

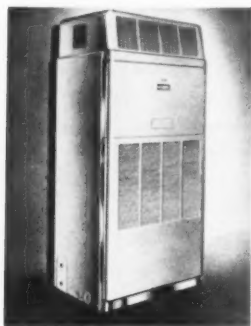
MARCH 1952

Edited by BESSIE COVERT

TO HELP YOU get information quickly on new products described in this section, we have provided the convenient Readers' Service Form on page 272. Check the numbers of interest to you and mail the coupon to the address given on the form. If you wish other product information, just list the items and we shall make every effort to supply it.

Self-Contained Air Conditioner

A new compact 7½ ton capacity self-contained air conditioner is being introduced by Frigidaire for cooling general offices, large waiting rooms, lounges and



other areas. It delivers 2700 cubic feet per minute of conditioned air and has an air throw of 75 feet.

The complete mechanism is located within a compact cabinet only 40 inches wide, 28 inches deep and 86½ inches high. Installation and operation are simple. Electrical, water and drain connections are all that are necessary. The simple controls are located behind a small access panel on the front of the cabinet. The unit is finished in two-tone gray. **Frigidaire Division, General Motors Corp., Dept. MH, Dayton 1, Ohio.** (Key No. 857)

Plastic Band-Aid Package

The new Band-Aid Plastic Strips are now available in a new professional package for hospitals and the medical profession, as well as in a new package for consumers. The professional package contains one hundred 1 by 3 inch strips. The extra width is provided in the professional packages for added protection. The new consumer package provides thirty ¾ by 3 inch strips and nine 1 by 3 inch strips. Both widths allow the same freedom of movement and comfort after application. **Johnson & Johnson, Dept. MH, New Brunswick, N. J.** (Key No. 858)

Tint Glass

A new greenish tint glass which absorbs the sun's heat, reduces eyestrain and keeps fading and bleaching of fabrics to a minimum is now available. It is designed for use in public buildings, automobiles, trains, buses and eventually in homes. Called Solex, the new flat glass product may be bent, laminated or tempered for use wherever flat glass is suitable. It takes the heat out of sunshine without sacrificing light transmission, and absorbs the red portion of the solar spectrum so that the light transmitted through it is the easier portion on the eyes. **Pittsburgh Plate Glass Co., Dept. MH, 632 Duquesne Way, Pittsburgh 22, Pa.** (Key No. 859)

Hi-Gloss Interior Panels

Economical modernization of hospital interiors can be accomplished through use of Marlite Hi-Gloss. This is a new, clear glossy prefinished wall and ceiling panel available, because of revolutionary manufacturing techniques, at relatively low cost. The permanently-bonded finish, produced by an exclusive Marlite high-heat-bake process, seals out dirt, grease, grime, moisture, alkalis and mild acids, thus providing a finish especially suited to many areas in the hospital. Cleaning and maintenance time are reduced since the finish can be cleaned by wiping with a damp cloth. The need for and expense of periodic decorating are eliminated.

Marlite Hi-Gloss is available in Plain, Horizontaline and Tile patterns in a complete range of colors to harmonize with any decorating plan. It is easily and quickly installed as the large, wall sized panels are quickly cut and fitted. Marlite Hi-Gloss is especially suited for wall surfacing material in entrances, corridors, waiting rooms, laboratories, operating rooms, kitchens and in other areas. **Marsh Wall Products, Inc., Dept. MH, Dover, Ohio.** (Key No. 860)

Lamidall Moldings

Wood-grain moldings to match perfectly any Lamidall wood-grain wall panels are now available. The new

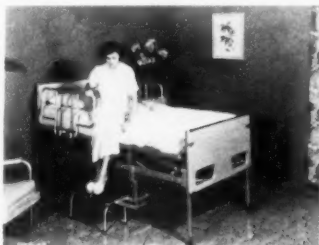
moldings are made of extruded aluminum with a decorative plastic laminated surface. Their use provides a continuous wall pattern effect with no noticeable break between panels, at corners, edges or tops. They are produced for use with ½ inch thick Lamidall panels for walls, ceilings and top surfaces. **Woodall Industries, Inc., Dept. MH, 3500 Oakton St., Skokie, Ill.** (Key No. 861)

Short Safety Sides

The new Hill-Rom Safety Side is a short, light weight guard which is attached to the head end of the bed only. It can be raised or lowered from one position to the other with one finger. It is made of anodized aluminum, weighs only seven pounds, and can be handled, attached and adjusted by even small nurses. The new sides can be easily attached to any hospital bed, wood or metal, including adjustable height beds.

The new sides were developed as a reminder rather than a restraint since if the patient has the physical strength, he may climb over the full length side guard and have a serious fall. With the short Safety Side the patient is kept from falling but can get out of bed if desirable. Also the side is a help to the patient in getting in or out of bed and in raising himself in bed.

The new Safety Side is attached to the head rest section of the spring. When the head rest is raised the Safety



Side travels along with it. The Safety Side does not interfere with use of the overbed table or with making up the bed. **Hill-Rom Company, Inc., Dept. MH, Batesville, Ind.** (Key No. 862)

(Continued on page 230)

Specified for
"1001"

SURGICAL USES: Vaseline Sterile Petrolatum Gauze

Adopted as standard procedure by surgeons, as preferred matériel by nurses, these superior dressings are used as wound coverings and packings, as plugs and drains—as well as being the most widely-used definitive dressing for burns and abrasions.

Adopted, because these ready-made dressings—packed in heat-sealed foil-envelopes—save time, motion, material... eliminate mess, bother, wastage, spoilage, equipment clean-up.

NOW IN THREE SIZES:

No. 1: 3" x 36"	(6 in carton)
No. 2: 3" x 18"	(12 in carton)
No. 3: 6" x 36"	(6 in carton)

**Insist on these superior dressings
 in the foil-envelopes**

CHESEBROUGH MFG. CO., Cons'd
 Professional Products Division
 NEW YORK 4, N. Y.

VASELINE is the registered trade-mark of
 the Chesebrough Mfg. Co., Cons'd



NEW!

**ELECTRIC-AIRE
 portable dryer
 DESIGNED AND ENGINEERED
 SPECIFICALLY FOR USE IN
 HOSPITALS!**

- Saves Personnel Hours
- Shortens Cast Drying Time
- Completely Portable & Adjustable

The Electric-Aire Portable Dryer fills the hospitals' urgent need for a dependable, portable, adjustable, quiet, fast drying, warm air unit. Its use will save hours of personnel's time, while giving safe, comfortable, fast drying treatments to patients.



CAST DRYING

The Electric-Aire Portable Dryer is used for fast setting and drying of any cast. Warm air can be directed to any portion of the cast. Temperature and velocity of the air can be adjusted and "locked" by nurse or attendants.



SHOCK TREATMENT & BED WARMING

Shock patients are quickly warmed by inserting the nozzle under bed coverings. A bed can be quickly and completely warmed in 3 to 5 minutes before receiving the patient.



HAIR DRYING

The Electric-Aire Dryer is unexcelled as a hair dryer. It can be placed at the patient's bedside and adjusted to any height or position... will dry the heaviest head of hair thoroughly in 3 minutes.



Flexible, rotating hose revolves in a complete 360° arc... adjustable to innumerable positions.



Drying unit revolves on its own axis in a 360° arc... giving an added six inches of movement...

Mounted on a sturdy, free rolling, heavy metal stand. The counter-balanced shaft permits Dryer to be elevated or lowered with ease. Safety lock screw prevents slipping. Height adjustment from 36" to 50". Casters spaced and unit weighted as to be practically non-tilting.

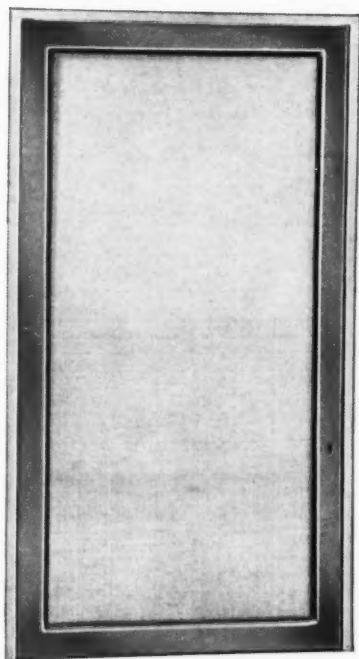
DESIGNED & ENGINEERED BY THE ELECTRIC-AIRE
 ENGINEERING CORP. . . . FOR MORE THAN 30
 YEARS SPECIALISTS IN THE ELECTRIC DRYING FIELD

Established Canadian Distribution

For Complete Details Write to: DEPT. H

ELECTRIC-AIRE ENGINEERING CORP.
 209 W. JACKSON BLVD., CHICAGO 6, ILLINOIS

At right, your most economical, long-run security-screen buy! Chamberlin Security Screens are, pound for pound, the heaviest, strongest made. They provide extra-long life at lowest possible maintenance cost.



Neurological Building,
Philadelphia General Hospital

What Philadelphia General Hospital bought in its 2,201 Chamberlin Security Screens



For use in its recently completed Neurological Building, Philadelphia General Hospital bought 2,201 Chamberlin Security Screens—306 Detention-type, 1,410 Protection-type, 485 *special* Protection-type.

About the latter: At time of purchase, Philadelphia General needed only insect screens for rooms that would *later* house disturbed patients. To avoid the expense of replacing complete insect screens when change-over was made, 485 Chamberlin Protection Screen frames with aluminum *insect screen* cloth were installed at the recommendation of the Chamberlin Advisory Service.

As disturbed patients occupy rooms, simple, inexpensive switch to Chamberlin's heavy stainless-steel wire cloth provides needed detention strength of Chamberlin Screens, which also act as insect screens.

To the obvious savings above, add important yearly maintenance savings *and* top security-screen performance—and you know what Philadelphia General Hospital bought in its 2,201 Chamberlin Security Screens. Check these famous Chamberlin features against *your* needs:

PERFORMANCE—Chamberlin Security Screens deliver safe, sure, humane detention and protection year in, year out. That almost goes without saying.

SAVINGS—Chamberlin Security Screens deliver important yearly savings. For instance, their extra-heavy construction outlasts severe attacks, usual forcing, prying, picking. Repair bills go down, stay down. Too, Chamberlin Security Screens stop glass breakage, grounds littering; cut maintenance costs substantially.

ADVISORY SERVICE—Chamberlin Advisory Service will help you save every possible cent, as it has done for architects, contractors, and institutional managements during 14 years of specialization in this field. Write for informative folder on Chamberlin Security Screens—Detention, Protection, or Safety types. Or let us give you exact data on the specific security-screen needs you have in mind.

Modern institutions turn to



For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSÉ ST.

• DETROIT 32, MICHIGAN

CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, All-Metal Storm Windows, and Insect Screens

What's New . . .

X-Ray Processing Hangers

Radically improved clip design is a feature of the new Kodak x-ray processing hangers. The new hangers also feature new pin design which permits better washing of film in clip areas and enables clips to stay cleaner longer, new thinner clip requiring less rack storage space, and loop guides which hold the bow springs and top clips in line so that hangers cannot tangle. Known as Kodak X-Ray Processing Hangers, No. 3A, the new products are made of stainless steel, easy to load and built for long life. They are available in the regular Kodak x-ray processing hanger sizes. Eastman Kodak Co., Dept. MH, Rochester 4, N. Y. (Key No. 863)

Fluorescent Luminaire

The new "Norwin" all-white 2 lamp fluorescent luminaire has an overall efficiency of 82 per cent. It is especially suited for use in classrooms, offices, drafting rooms and other areas where high-quality, low cost illumination is required. The new luminaire is clean cut in appearance, has a rugged chassis, egg-crate louver assembly which hinges from either side for quick, easy maintenance, and 25 degree crosswise and 35 degree lengthwise shielding. No tools

are required for servicing the "Norwin" which may be surface or pendant mounted, individually or in a continuous row. Pittsburgh Reflector Co., Dept. MH, 419 Oliver Bldg., Pittsburgh 22, Pa. (Key No. 864)

Tube Brush



A new brush is being introduced which is specifically designed for cleaning constriction tubes. It slides easily through narrow tube openings and thoroughly scrubs every part of short, long and double-end tubes. A special fan tip assures complete cleansing of round tube ends. The brush is 6½ inches long with bristles ½ inch in diameter on a 3¼ inch head. American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 865)

(Continued on page 234)

Cable Wire Suture

Two new packaging innovations have been announced for convenience in handling "Cable-Wire" sutures, the twisted wire fine sutures with the pliability of silk. Many strands are used to form a smooth, unbreakable suture of extreme flexibility. The 100 feet spools are packed in new transparent plastic boxes for instant checking and elimination of waste. The sutures are also packed in cardboard tubes with one dozen strands of the same size sutures in 20 inch and 12 inch lengths to save nurses' time in pre-operative preparation. United Surgical Supplies Co., Dept. MH, 160 E. 56th St., New York 22. (Key No. 866)

Floor Repair

Trowel In is a new floor patching and resurfacing material which can be kept on hand ready for immediate use in case of need. It both repairs and resurfaces floors of concrete, stone or brick. It requires no heat or special skill in application and no sand, cement or stone for mixing. It can also be used to help set floor plates and drains and can be troweled in easily around machine bases, pipes and other obstructions. Flexrock Co., Dept. MH, 3699 Cuthbert St., Philadelphia 4, Pa. (Key No. 867)

Refinite serves the World

Refinite WITH WATER CONDITIONING EQUIPMENT & SERVICE

Refinite OMAHA, NEB.

WATER REFINING EQUIPMENT

WRITE FOR FREE BULLETINS ON HOW REFINITE CAN SERVE YOU. ADDRESS: DEPARTMENT MH-A

FLOOR MACHINE

Sun Ray WOOLERS*

beautify and protect all floors!

*Trademark

All types of floors . . . wood, terrazzo, marble, linoleum, and rubber, asphalt or ceramic tile . . . are made more beautiful with Sun Ray Woolers! Used with any single disc-type floor machine, Sun Ray Woolers provide an efficient, effortless way of cleaning, dry scrubbing, polishing, and wax-finishing any floor surface!

Write today for free descriptive literature!

Sun Ray Another Steel Wool Product Manufactured By

THE WILLIAMS COMPANY

250 WEST FIRST STREET • LONDON, OHIO



Typical patient room, Georgia Baptist Hospital

ARCHITECT: STEVENS & WILKINSON, ATLANTA, GA.

Georgia Baptist Hospital,
Atlanta, Georgia



*A remedy for noise
... a Fire-Safe cure*

**... WITH FIBERGLAS*
ACOUSTICAL TILE**



Kitchen, Evanston Hospital, Evanston, Illinois

Making every room a "quiet zone" in your hospital can be accomplished for surprisingly little with Fiberglas Acoustical Tile. It's one of the lowest cost mineral-type acoustical materials available. It will not burn or contribute to the spread of fire.

Inherently sanitary and dimensionally stable, Fiberglas Acoustical Tile will not warp—provides no sustenance for vermin or rodents—neither absorbs nor gives off odors.

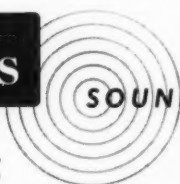
If you are planning modernization of your hospital, or building a new one, ask your architect or contractor to specify Fiberglas Acoustical Tile. There's a Fiberglas acoustical contractor listed in the yellow pages of your phone book. Call him today, or write to: Owens-Corning Fiberglas Corporation, Dept. 141-C, Toledo 1, Ohio.

- **High Acoustical Value**
- **Good Light Reflection**
- **Easily Applied**
- **Decorative Beauty**
- **Washable—Paintable**
- **High Insulation Value**
- **Non-combustible**

OWENS-CORNING
FIBERGLAS

SOUND CONTROL PRODUCTS

*Fiberglas is the trade-mark (Reg. U.S. Pat. Off.) of Owens-Corning Fiberglas Corporation for a variety of products made of or with fibers of glass.



Acoustical
Tile



Noise-Stop
Baffles



Ceiling
Board



Membrane Faced
Acoustical Tile



Nurseries ... Operating Rooms ... Entrances ... Hydrotherapy ... Food Storage Trane Air Conditioning Serves Everywhere in the Hospital

Hospital heating, ventilating and air conditioning problems of any size or complexity can be handled by the Trane line.

In Nurseries ... where drafts and fluctuating temperatures are taboo, Trane Convectors protect infants by pouring a blanket of heat over cold walls and windows, by gently circulating this clean, easily controlled warmth to all parts of the room. In corridors, patient rooms, offices and throughout hospitals, these compact wall-hugging successors to the cast iron radiator save valuable floor space and provide dependable, low-cost heat.

In Operating Rooms ... dry air complicates surgery with rapid tissue dehydration. It also encourages static sparks ... always a hazard near inflammable anesthetic fumes. By increasing humidity to the proper degree, Trane Climate Changers relieve this danger. In addition, they promote comfort and efficiency by supplying heated or cooled air, filtered and blended with fresh outdoor air.

At Entrances ... busy doors admit icy blasts that cause

uncomfortable cold drafts in waiting rooms and corridors. Trane Force-Flo Heaters supply a curtain of heat that neutralizes this cold air at its source.

In Hydrotherapy ... humidity and stale air can quickly become unpleasant. To solve the problem, Trane Unit Ventilators blend fresh outdoor air—filter, heat and circulate it as desired.

In Food Storage ... spoilage, shrinkage, vitamin losses and danger of contamination are always a problem. Trane Cooling Coils team up with Trane Fans in a minimum of space to provide ideal storage conditions that keep foods fresh and safe longer.

Whether it's operating rooms, nurseries, entrances, hydrotherapy or food storage, Trane heating and air conditioning serves everywhere in the hospital.

Whatever your hospital heating, cooling, ventilating or air conditioning problem is, look for the answer in the complete Trane line.



Whether it's the busy front entrance or an emergency doorway, Trane Unit Heaters blanket it with heat to offset heat loss and check icy drafts.



In physiotherapy rooms where ventilation without drafts is needed, Trane Unit Ventilators serve efficiently from safe, round-cornered cabinets.



One of the multitude of hospital jobs handled by Trane Coils and Fans is the cooling and refrigerating of food storage rooms and walk-in lockers.

TRANE

MANUFACTURING ENGINEERS
OF HEATING, VENTILATING AND
AIR CONDITIONING EQUIPMENT.

THE TRANE COMPANY, LA CROSSE, WIS.
Eastern Mfg. Division, Scranton, Pa.
Trane Company of Canada, Ltd. ... Toronto

OFFICES IN 80 U. S. AND
10 CANADIAN CITIES

The MODERN HOSPITAL

Foot Gripping Power on Your Floors

with

Ves-COTE FLOOR WAX

ANTI-SLIP PROTECTION



When you step on Ves-Cote, the weight of the foot forces the hard "Ludox" colloidal silica spheres into the wax particles, providing superior gripping power. This way Ves-Cote gives greater slip protection.



Approved by the Underwriters Laboratories.

VESTAL INC. 4963 Manchester
St. Louis 10, Mo.

One sure way to reduce falls caused by slippery floors . . . is to finish your floors with Ves-Cote.

There is a reason: Ves-Cote contains "Ludox"®, DuPont's new colloidal silica. These millions of tiny "Ludox" particles—integral parts of Ves-Cote—act as "stoppers" whenever a shoe touches them . . . actually grip the shoe with each step.

But, safety isn't the only feature of Ves-Cote: in addition, it dries to a high lustre, is long wearing, water resistant and easy to apply.

With Ves-Cote, you can have eye-pleasing floors that are *safe* to walk on . . . try Ves-Cote and the results will convince you.

Mail This Coupon TODAY!

VESTAL, INC., 4963 Manchester, St. Louis 10, Mo.

- ☐ Have your Vestal representative demonstrate VES-COTE for me.
- ☐ Send me a FREE copy of FLOOR FACTS—A guide for treatment and maintenance of all types of floors.

NAME

ADDRESS

CITY

STATE

What's New . . .

Incandescent Lighting Products

A group of new, wide area prismatic units for incandescent lighting applications has been introduced. They are the first of 75 new products which will be released throughout the next seven months. Designed for lighting building entrances, gate entrances, garage courts, driveways, storage areas and yards, the new units have weather-proof construction and attractive, modern lines. The upward light from the lamp is redirected to downward light by the inner reflecting surface of the hood. The downward reflected light and the downward light from the lamp are bent upward and outward by the prismatic glass to give extended light distribution for protective as well as utility lighting over wide areas. It also provides high angle light for effective illumination of upper vertical surfaces. The radius of effective light coverage is upwards of five times the mounting height above the ground or floor. **The Art Metal Co., Dept. MH, 1814 E. 40th St., Cleveland 3, Ohio. (Key No. 868)**

"Tiny Tot" Wheel Chair

A miniature of the Everest & Jennings "Standard Universal" Model Wheel Chair is now available for children up

to five years of age. Footboards are adjustable for different ages and the chair is designed so that the child can maneu-



ver it by wheel handrims. A plastic grip pushing handle is provided for an attendant when desired.

The "Tiny Tot" Wheel Chair is ruggedly constructed of chromium plated tubular steel with sturdy leatherette hammock seat and head height back. It is built to stand up under any abuse which might result from use by children. Upholstery is of U.S. Naugahyde Plastic which is acid resistant, water repellent and easily cleaned with soap and water.

(Continued on page 238)

It is available in several colors. When not in use the chair folds with one easy motion into a compact form for storage and easy transportation. **Everest & Jennings, Dept. MH, 761 N. Highland Ave., Los Angeles 38, Calif. (Key No. 869)**

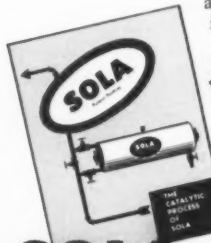
Reach-In Freezer

The new Jordon upright Reach-In Type Freezer for frozen food storage has a total storage capacity of 15 cubic feet or approximately 500 pounds of food. A quick-freezing ice cube tray shelf with five ice cube trays is included in the Jordon Model UF-15. The unit is engineered with refrigerated freezer plate shelves which puts every food package either in direct contact with a freezing surface or in close proximity to it.

The new UF-15 requires a minimum of floor space, is 72 inches high, 40 inches wide and 31 inches deep, including door and hardware. It permits easy cataloging of contents and a closer check of inventory. All food is within convenient reach and at eye level. The freezer cabinet has a continuous 6 inch blanket of Fibreglas insulation and is refrigerated by a hermetically sealed refrigeration system. **Jordon Refrigerator Co. Inc., Dept. MH, 58th and Grays, Philadelphia 43, Pa. (Key No. 870)**

SOLA CATALYTIC PROCESS
Eliminates
SCALE
AND REDUCES RUST
in Boilers, Heaters & Water Systems

SOLA is the modern Catalytic process that prevents the formation of scale and gradually reduces old scale and corrosion in hot and cold water systems, creating crystal clear water without any change to the chemical structure. Less expensive than any other treatment. Simple to install and operate.



Send for **FREE BOOKLET** No. 19

NAME _____
ADDRESS _____
CITY _____

SOLA CATALYTIC CO.
520 BROWDER ST., DALLAS, TEXAS

Send for this Helpful Bulletin



SINGLE ROOM LAYOUTS
DOUBLE ROOM LAYOUTS
"EASY-ON-THE-BUDGET"
FURNITURE DESIGNS
NEW, MODERN
FUNCTIONAL UNITS
37
ILLUSTRATIONS

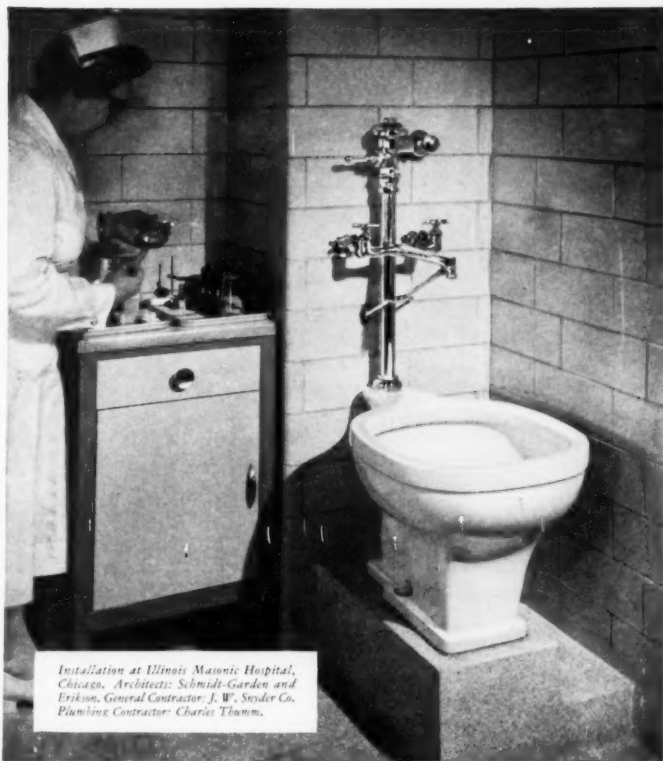
EICHENLAUBS
For Better Furniture
3501 BUTLER ST., PITTSBURGH 1, PA.
ESTABLISHED 1873

THE PREFERRED HOSPITAL PLUMBING

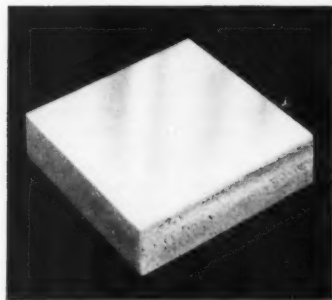
Crane's Highly Perfected CLINIC SINK

Typical of Crane's full line of specialized fixtures for hospital use, this Crane Clinic Sink is designed with studied respect for every possible contingency in use. Like all Crane hospital fixtures it was perfected in co-operation with medical authorities.

See your 1952 Hospital Purchasing file for information on the *improved* Crane Line of hospital fixtures. Select them through your Crane Branch, Crane Wholesaler, or local Plumbing Contractor.



Installation at Illinois Masonic Hospital, Chicago. Architects: Schmidt-Garden and Erikson, General Contractor: J. W. Snyder Co. Plumbing Contractor: Charles Thumm.



MADE OF LASTING

Duraclay

This genuine vitreous glazed earthenware, developed by Crane Co. for large sanitary fixtures has been proved in hospital service for more than 10 years. Its homogeneous texture withstands thermal shock and its glistening glazed surface is proof to acid, stain and abrasion—wipes clean with a damp cloth!

FEATURES

Bigness that permits easy emptying of bedpan and buckets without touching ware.

Bigness of water surface that minimizes soiling, improves sanitation.

Dial-use Control for smoothness of operation and blending without sudden temperature changes.

Dependable flush valve and full syphonic flushing action. Large trapway that passes wads of cotton and gauze without clogging. Bowl equipped with flushing rim for maximum sanitation.

Pedestal mounted, for convenient height, waste may be run to floor or wall.

CRANE CO.

GENERAL OFFICES: 836 SOUTH MICHIGAN AVE., CHICAGO 5
VALVES • FITTINGS • PIPE
PLUMBING AND HEATING

AERO-KROMAYER by HANOVIA



FOR ACCURATE
CONTROL IN LOCAL
ULTRAVIOLET
APPLICATION

Designed, developed and engineered specifically for highly concentrated ultraviolet therapy under accurate focus and dosage, the Aero-Kromayer has a wide field of clinical usefulness.

The Aero-Kromayer is completely air-cooled — operates in any desired position while delivering a constant, high-intensity output—and its various applicators are designed for any skin surface and orificial irradiation that may be required.



Just off the press — new booklet,
"Ultraviolet Radiations in Eye, Ear,
Nose and Throat Conditions," free on
request. Write Dept. 315-G

HANOVIA

Chemical & Mfg. Co., Newark 5, N. J.



**FASTER and SAFER
HANDLING of WALL
and CEILING AREAS...**



**WITH
BAKER
SCAFFOLDS**

● The Baker Scaffold, with its fully adjustable platform, allows the placement of men at different levels, so that wall areas may be covered faster. The large working platform (13.8 sq. ft.) is adjustable for every 3 inches of height, even when units are stacked to reach high ceilings.

Self-locking trusses give added security and speed in assembly. There are no bolts, nuts or other loose parts to be lost. The absence of "X-Braces" permit the use of Baker Scaffolds in occupied areas . . . they readily span furniture, machinery, stockpiles and equipment.

Write today for the name of our nearest distributor who will be glad to give you complete information on Baker Scaffolds for your particular application.

Write today for Bulletin 522

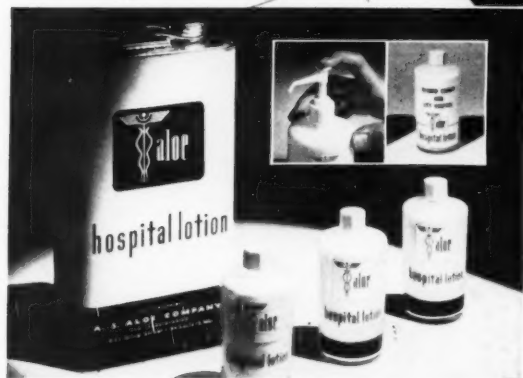
Distributors in principal cities.
Listed under Reexamination Service,
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BAKER-ROOS, INC.
602 W. McCARTY STREET
INDIANAPOLIS 6, INDIANA

TWO NEW ITEMS

...for more efficiency
...for more economy



Aloe Hospital Lotion—More economical, superior to alcohol for body massage

Now available with label bearing name of hospital

Aloe Hospital Lotion is stimulating, refreshing, and cooling. Contains lanolin, pure olive oil, natural menthol, stearic acid, propylene glycol, magnesium stearate and hexadecanol. Comes in handy 8-ounce bottles or gallon cans from which refills of bottles may be made. Each bottle has a sand-blasted patch for writing patients' names and room numbers. Bottles are packed 3 dozen to a carton.

JS3693A—Aloe Hospital Lotion, 8-ounce bottle, in 3 dozen lots (1 carton), per dozen	\$3.85
In 12 dozen bottle lots, per dozen	3.45
In 60 dozen bottle lots, per dozen	3.40
JS3693A—Same, but Personalized Label, in minimum lots of 144 dozen bottles, per dozen	3.10
JS3693B—Same, in 1 gallon cans, per can	3.65
In lots of 4 cans, per can	3.55
In lots of 8 cans, per can	3.35
In lots of 20 cans, per can	3.25
JS3693C—Plastic Lotion Dispenser, finger-operated pump type; screws on 8-ounce bottle, per dozen	2.20

New Tornado Garment—For Involuntary and Incontinent Patients

Provides ideal protection for ambulatory cases

This recent development for difficult invalid cases is a water- and acid-proof garment designed to be worn by ambulatory or bedridden patients who are involuntary or incontinent. The material is made of Firestone Velon, electronically welded and fashioned in five sizes. Velon is soft and pleasant next to the skin and will not become hard and brittle after repeated use. Pockets front and back are designed to hold cellulocotton and therefore supply immediate absorbency. The garment may be laid out flat and the patient rolled onto it. Ties and snaps provide adjustable fitting and required ventilation. Fit in crotch holds the padding in correct position at all times. Because the garment fits smoothly back, front, and sides, it is ideal for ambulatory patients. Easy to clean; may be washed with soap and water. Withstands heat. In ordering, give waist measurement in inches. Available in the following sizes: Junior, 25-31; small, 27-32; medium, 31-37; large, 37-42; extra large, 42-48.

JS3824—New Tornado Invalid's Garment (please specify size), each	\$4.25
In lots of 6, each	4.00
In lots of 12, each	3.50

Sizes may be assorted to obtain quantity prices.

a. s. aloe company

AND SUBSIDIARIES

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LOS ANGELES • NEW ORLEANS • KANSAS CITY • MINNEAPOLIS • ATLANTA • WASHINGTON, D. C.

What's New . . .

X-Ray Control

The new Fluoradex "500" MA X-Ray Control is completely automatic. It is electronic in operation and quiet in use. It has thirty-two electrically timed stations for radiography and spot film and may be adjusted to any of six stations between 10 and 500 MA, as desired. It is only necessary for the doctor or technician to position the patient and push the x-ray switch; the actual exposure and other factors are entirely automatic. The unit may also be used as a manual control for unusual x-ray techniques. It is compact in design and may be installed either against the wall or in the wall for flush installation. **Westinghouse Electric Co., X-Ray Div., Dept. MH, 2519 Wilkens Ave., Baltimore 3, Md. (Key No. 871)**

Hydrotherapy Baths

A series of hydrotherapy baths, for immersing leg, arm, leg and arm, or the whole body, is available for vigorous, vertical water action, simulating massage. The **Rocke Hydrotherapy Baths** are constructed of 16 gauge stainless steel, seamless welded with beaded rims. The circulator motors are rubber mounted and enclosed in a section separated from the tank. The compact units

occupy a minimum of floor space, are self-contained so that there are no installation problems, and are equipped with



four ball bearing swivel casters for easy mobility.

Model 45, illustrated, is a twin-turbine unit for treatment of part or full body. The inside dimensions are 22 inches wide, 22 inches deep and 46 inches long. It has three switches, for individual circulator motors and the drain pump. Other models are designed for treatment

of leg and arm at the same time and for the feet, lower limbs and arms. The **Rocke Hydrotherapy Baths** have been accepted by the Council on Physical Medicine of the American Medical Association. The twin-turbine circulators are designed to aerate the entire tank so that there are no dead spots and uniform action is provided throughout the tank. **Wm. Rocke Co., Inc., Dept. MH, Box 623, Bloomington, Ill. (Key No. 872)**

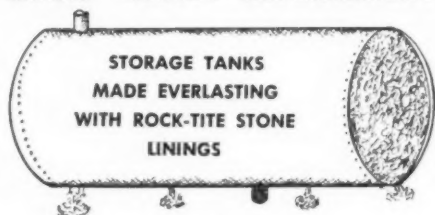
Soft Drink Dispenser

Four different flavors of carbonated soft drinks, plus plain soda and ice water can be dispensed from the new soft drink dispenser recently introduced. It comes in a variety of models with three-way faucets available on either the front of the cabinet or the gooseneck type on the top of the cabinet. It is complete with an attached cabinet for syrup tanks which can be kept away from the dispenser or left attached.

The new **Uniflow** dispenser incorporates a Liquid Carbonic carbonator with the necessary refrigeration, fittings, gauges and restrictors. It should be of interest for snack bars, personnel quarters and nurses' homes as well as for lunch rooms and cafeterias. **Uniflow Mfg. Co., Dept. MH, East Lake Rd., Erie, Pa. (Key No. 873)**

(Continued on page 242)

AVOID COSTLY REPLACEMENT



- The cost is less than for a new tank.
- The job can be guaranteed forever.
- Insured by **LLOYDS OF LONDON** against loss or repair from rust and other forms of corrosion.

ROCK-TITE STONE will rehabilitate pitted, leaky or over-aged storage tanks of all types. The lining insures clean, sanitary conditions and provides positive protection against costly maintenance. **ROCK-TITE** will protect new installations as well as salvage old tanks.

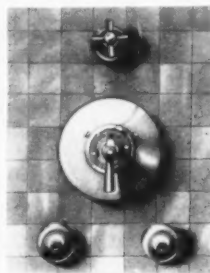
Installations in Service Over 20 Years

ROCK-TITE STONE linings are used by leading hospitals, schools, colleges, hotels and industrial plants throughout the country.

Write today for descriptive brochure

CHAS. J. RILEY & SONS
6352 N. Maplewood Chicago 45, Illinois

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LEONARD
by U.S. Pat. Off.
Thermostatic
WATER MIXING VALVES

The Standard of Excellence
in
SHOWER MIXING VALVES

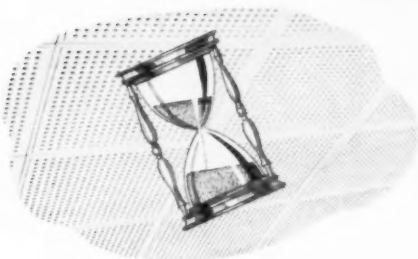
For accurate control of showers, sitz baths, X-ray sinks, arm and leg baths, in fact wherever water temperature is to be controlled, there is a **LEONARD VALVE** "Designed for the Installation."

Write for Catalog H
Condensed.

Representatives in Principal Cities.

LEONARD VALVE COMPANY
1360 Elmwood Avenue, Cranston 7, R. I.

Interesting facts about acoustical materials



How long are acoustical materials effective?

Any good acoustical material will retain its noise-quieting properties indefinitely. Even repeated painting will not harm the efficiency of a material like Armstrong's Cushiontone. All Armstrong acoustical materials are durable . . . won't warp, shrink, or mold in normal humidity . . . and won't harbor vermin or odors.



Why are some materials perforated and others "fissured"?

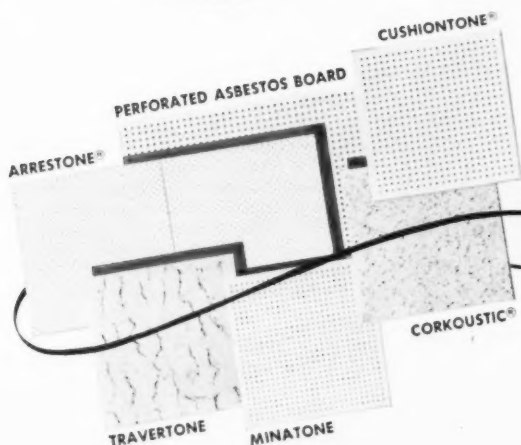
Acoustical materials have surface openings where sound may enter and be absorbed. Materials like Armstrong's Cushiontone, with geometric perforations, offer high efficiency at lowest cost. Fissured materials like Travertone have been designed for interiors where unusual beauty is required.



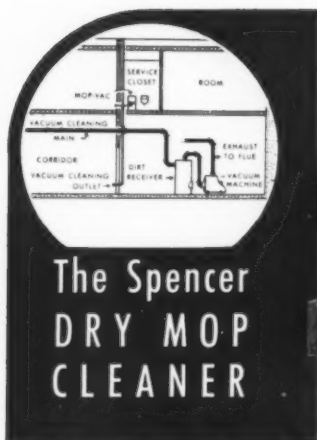
Can acoustical ceilings be applied to curved surfaces?

Because acoustical materials are made in small tile form, they can be cemented directly to surfaces where the curve is very gradual. Where the material itself must actually bend, however, Armstrong's Corkoustic is recommended. Corkoustic, made of pure cork, offers some flexibility.

FREE BOOKLET: "How to Select an Acoustical Material" answers many questions about sound conditioning. Write Armstrong Cork Company, 5703 Stevens Street, Lancaster, Pennsylvania.



**ARMSTRONG'S
ACOUSTICAL
MATERIALS**



The Spencer DRY MOP CLEANER



Hospitals equipped with Spencer Vacuum Cleaning will never have a dry mop cleaning problem. A Spencer Mop-Vac cabinet is located in a service closet on every floor. No extra steps—and all the dust goes down the vacuum system to the basement.

The Mop-Vac consists of a slotted plate mounted flush in the floor or on a box cabinet with a foot operated valve. Open the valve and air rushes through the slot. Pass the mop over the slot and the high velocity air agitates the strands, and removes the dust. Dust cloths are cleaned the same way.

Standard Spencer Vacuum Tools connected to the Stationary System may also be used for general cleaning of floors, walls, furniture, mattresses or hard-to-reach places, such as air conditioning ducts and grills.

SIX DIFFERENT TYPES

Cabinet units are made in three types: The open type illustrated above, and high and low enclosed cabinet types.

The simple attachment illustrated at the right may be inserted in the Spencer baseboard inlet valve. The Spencer floor valve may be connected to the pipe system under the floor, and a box type is available for attaching to the Spencer Portable Vacuum Cleaner. Ask for Bulletin No. 138-C on Spencer Mop-Vac and Bulletin No. 133 on Stationary Vacuum Cleaning Systems.



THE SPENCER TURBINE COMPANY • HARTFORD 6, CONNECTICUT

SPENCER
HARTFORD

450-A

club chair 5121

Overall—
Width 28"
Depth 32"
Height 30"
Also without
arms



low back chair 3406

Overall—
Width 28"
Depth 29"
Height 29"
Also without
arms



high back chair 3407

Overall—
Width 28 1/4"
Depth 30 1/2"
Height 42"
Also without
arms



Thonet gives you these advantages

- **quality**—the finest in furniture since 1830
- **styling**—exclusive designs, lovely finishes
- **durability**—sturdily built for years of service
- **comfort**—engineered for maximum ease
- **planning service**—layouts and blueprints
- **price**—most reasonable because of our large volume production

Write for illustrated folder.



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INDUSTRIES, INC.

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NEW YORK 16, N. Y.

SHOW ROOMS:
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STATESVILLE, N. C. • DALLAS



Trucks

for Fast, Quiet Handling of Trays and Dishes

**Now Stainless Steel
for Sanitation, Durability
and Appearance**

- ★ **Sanitary** — easy to clean — no cracks or crevices to invite bacteria.
- ★ **Durable** — life-time finish, sturdy welded construction, rugged wheels and casters.
- ★ **Bright** — cheerful, rust-proof stainless steel.



Model 10 — 6332 Stainless Steel Tray Truck . . .
Corner posts are 1 1/2" diameter stainless steel tubing. Heavy gauge shelves have double thick edges for extra strength and an embossed recess helps keep trays in place. Heavy-duty rubber bumper protects truck, other equipment and walls. Swivel type ball-bearing casters with cushion-rubber tires float heavy loads quietly—effortlessly. This deluxe tray truck is one of over 30 different COLSON models.



Model 10 — 6406-6 Stainless Steel Dish Truck . . .
These Colson dish trucks are attractively styled and sturdy enough to provide many years of efficient service. Edges are double thick for extra strength, frame is 1 1/2" tubular stainless steel, shelves are 16 gauge type 302 stainless-clad. All joints are welded, ground smooth and polished. Front wheels are 10" diameter, rear wheels are 5"—all have replaceable cushion-rubber tires and ball-bearing hubs to insure fast, quiet operation.

Write for catalog H-2 for details on the complete line of COLSON wheel equipment for hospitals and institutional use, or consult the yellow pages of your phone book (under "Casters") for the local COLSON office.

THE COLSON CORPORATION

ELYRIA, OHIO

CASTERS • INDUSTRIAL TRUCKS AND PLATFORMS • LIFT-JACK SYSTEMS • BICYCLES • CHILDREN'S VEHICLES
WHEEL CHAIRS • WHEEL STRETCHERS • INHALATORS • TRAY TRUCKS • DISH TRUCKS • INSTRUMENT TABLES

What's New ...

Room Air Conditioner

Carrier has added a new, low-priced $\frac{1}{2}$ h.p. window sill model to its line of room air conditioners. It embodies the same engineering, construction and design standards featured in the present line of $\frac{1}{2}$ to $1\frac{1}{2}$ h.p. models. The model was developed to meet the demand for room air conditioners for small offices, small patient rooms and other spaces which do not require larger capacity air conditioning equipment.

The new unit uses the Carrier vibrationless hermetic compressor and has a streamlined heavy gauge cabinet. It is being produced in the new pearlescent finish which is designed to harmonize with any room decorative scheme. Window mountings are equipped with a special new weatherproof seal which has been tested to withstand wind and rain. Fingertip controls can be set for cooling and dehumidification with either outside or room air, or for ventilation only with filtered outside air. **Carrier Corporation, Dept. MH, Syracuse 1, N. Y. (Key No. 874)**

X-Ray Film Corner Cutter

The new Picker cast metal, hand operated x-ray film corner cutter has chrome plated guides along the edges

to facilitate placing the film in the cutting position. A transparent guard provides protection against the cutting edge



while permitting visualization of the position of the film being cut. The cutter is simple and positive in operation and eliminates sharp and jagged corners of film. It cuts the corner of film cleanly on a circular arc. The cutter is finished in glossy black. **Picker X-Ray Corp., Dept. MH, 25 S. Broadway, White Plains, N. Y. (Key No. 875)**

Plumbing Maintenance Tool

Removable faucet seats can now be accurately reformed with the new type

cutter for the patented Bibb Seat Reforming Tool. With the new tool, it is unnecessary to carry a large inventory of types and sizes of replacement seats and time is saved in searching for the proper size. With the new Sexauer Removable Seat Cutter, the same removable seat can be reformed three or four times, as needed, and the job of reseating can be done in three minutes. Use of the new cutter widens the seat, thus increasing the surface contact with the washer, producing easier shut-off and lengthening the life of the washer. **J. A. Sexauer Mfg. Co., Inc., Dept. MH, 2503 Third Ave., New York 51. (Key No. 876)**

Refrigerator Suction Valve

A new suction valve of the plate type for use in refrigerating machines using ammonia is being introduced by Frick Company. Known as the Garland, the new valve has moving parts weighing one sixteenth as much as those in the former valve and the ring plate has an opening on each side, giving the same port area with about half the lift. The Garland valve is a complete assembly. It is made interchangeable with former poppet valves in Frick ammonia compressors of the vertical enclosed type. **Frick Company, Dept. MH, Waynesboro, Pa. (Key No. 877)**

(Continued on page 246)

Watchword for Watch-watchers



For today's BUSY physician—
it's "Foilie First in First Aid"
in the treatment of burns, minor
wounds, abrasions in office,
clinic or hospital.

ANTISEPTIC • ANALGESIC

FOILLE

EMULSION • OINTMENT

*You're invited to request samples and clinical data.

CARBISULPHOIL COMPANY
2929 SWISS AVENUE, DALLAS, TEXAS

EVERY SECOND LOST

200

COULD HAVE LOST A HUMAN BEING

CHILDREN SAFELY ESCAPED RAGING FIRE



HOSPITALS AND INSTITUTIONS

Equipped with POTTER SLIDE TYPE ESCAPES provide the SAFEST and QUICKEST method of evacuating Patients, Nurses, Internes, Doctors and Attendants. Write for details.

Over 9,000 in service on two to 34 story buildings, saving 44 sq. ft. of usable floor space on each floor instead of stair wells.

POTTER MFG. CORPORATION
6118 N. California Ave. CHICAGO 45, ILL.
For QUICK DETAILS, PHONE COLLECT (ROgers Park 4-0098)

RIGHT IN YOUR OWN BACK YARD...

BY WEST



THE MORAL TO OUR STORY? Make the job easier for your maintenance personnel... and you automatically lower your maintenance costs. Let 'em wax as they clean—with a specially formulated material that performs 3 operations in one!

LUSTRECLEAN (pine-scented or plain) cleans... deodorizes... and deposits a light film of wax. Effective on any type of surface! No heavy scrubbing. No rinsing. Mop dry... buff the film lightly if a soft satiny finish is desired! Save time and labor cleaning floors, walls, woodwork—wherever excessive wear and heavy traffic has made daily maintenance a back-breaking job.

LUSTRECLEAN really cleans! Its emulsifying action loosens the most persistent dirt, grime... hard-to-remove rubber burns. No need to use harsh soaps or injurious chemicals. Proof? Ask for a sample and test it on the spots and blemishes your present cleaner won't remove!

Pine LustreClean is only one of many WEST products formulated for the promotion of sanitation. Others include floor sealers and waxes... washroom service... disinfectants... deodorants... insecticides... cleaners... soaps... protective creams. West is the exclusive distributor of Kotex Sanitary Napkins sold through vending machines.



42-16 West Street
Long Island City 1, N. Y.
(64 BRANCHES IN U.S. AND CANADA)

SAVE \$ \$ \$... WAX as you WASH

I'd like to try a sample of LustreClean

Pine-Scented ☐ Plain ☐

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Company _____

Address _____

City _____ Zone _____ State _____

Dept. 12

AMERICA'S GREATEST NAME
IN HOSPITAL
CUBICLES!



CAPITAL CUBICLES

AVAILABLE IN:

BRASS • STAINLESS STEEL
ALUMINUM, LUSTROUS FINISH

OUTSTANDING ADVANTAGES!

COMPLETE PRIVACY:

Installed in wards, semi-private, first aid, examination rooms; and in x-ray, hydrotherapy, dental, basal metabolism and other departments. Capital Cubicles provide maximum light and air, and enable nurses to render quicker medication and attention to the patient.

SMOOTH, EFFICIENT OPERATION:

Patented features of Capital Cubicles prevent hooks from catching or jamming, and assure quick, quiet, dependable operation.

EASY INSTALLATION:

Delivered complete with each cubicle and curtain keyed. Quickly installed with conventional carpenter's tools or, if desired, we will install at nominal cost.

LOW COST:

The initial cost of Capital Cubicles are the lowest on the market. *There are no maintenance costs to consider!*

CURTAINS:

Capital Cubicle curtains are of special closely-woven jean cloth, non-transparent and sanforized shrunk. In white and restful fast colors. Substantial rust-proof eyelets will not pull out or stain the cloth.



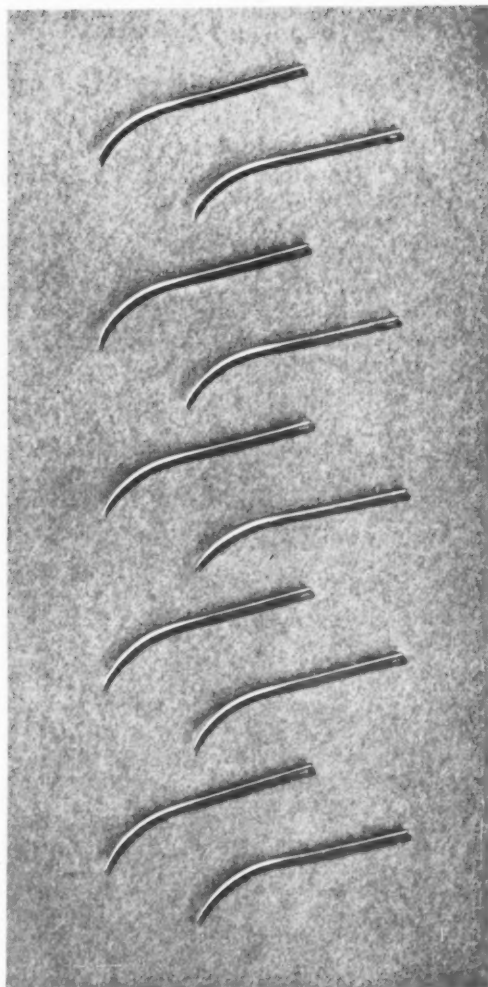
CURTAIN HOOKS OPERATE INSIDE TRACK - CANNOT BE REMOVED OR LOST. CANNOT SCRATCH FINISHED SURFACE.

SEND FOR ADDITIONAL DETAILED INFORMATION

... include rough sketch of room, indicating bed positions. We will submit plans, specifications and cost. No obligation, of course.

CAPITAL CUBICLE CO., INC.

213 25th STREET, BROOKLYN 32, N. Y. • 50uth 8-1022



PRECISE ACCURACY IN EVERY DETAIL
assured by modern
manufacturing methods

TORRINGTON stainless steel surgeons needles

Order from your hospital supply dealer. Catalog on request.

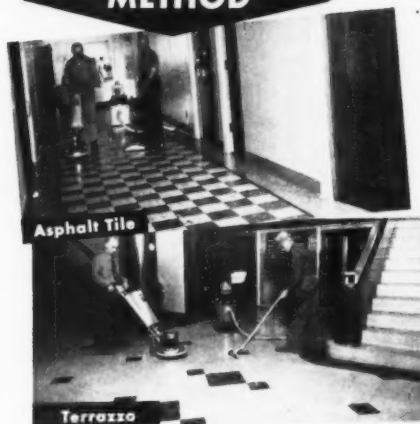
THE TORRINGTON COMPANY, Torrington, Conn.

Specialists in Needles since 1866

THE MULTI-CLEAN METHOD

IT'S DIFFERENT! ... NOW LASTING BEAUTY
... LESS UPKEEP ... FOR ALL YOUR FLOORS

... THIS NEW IDEA IN FLOOR MAINTENANCE IS BEING ACCEPTED
BY MORE AND MORE ENTHUSIASTIC USERS EVERY DAY!



For ASPHALT TILE FLOORS ... From now on you won't have to wax those asphalt tile floors to keep them good-looking and well protected. Multi-Clean Asphalt Tile Preserver is a complete finish in itself ... it provides a long-lasting, glossy finish, and is U. L. approved as anti-slip. It ensures continuing beauty and protection for all your asphalt tile. If you prefer to continue waxing your floors, you'll find Asphalt Tile Preserver an excellent base for wax. It makes the wax look nicer and saves you money because less wax is needed. With the *Multi-Clean Method*, ordinary dry sweeping or vacuuming and weekly damp mopping keep asphalt tile clean ... buffing with a Multi-Clean Floor Machine equipped with a polishing brush or steel wool disc will restore the original lustre.

For TERRAZZO FLOORS ... Now your terrazzo floors can have a brilliant lustre yet be extra-safe to walk upon when they are protected by Multi-Clean Terrazzo Sealer ... the terrazzo treatment approved anti-slip by U/L. It penetrates and seals the surface against moisture, dirt and grease. Water-clear in color, it will not yellow with age. It gives your terrazzo a beautiful satiny finish. Floors are ready for traffic within 30 minutes after application. This *Multi-Clean Method* requires only dry sweeping and periodic wet mopping for maintenance.

For CONCRETE FLOORS ... Two types of concrete floor treatments, each formulated to meet your own special floor condition are available to you with the *Multi-Clean Method* of floor care. Both Multi-Clean Neo-Dry Concrete Sealer (rubber-base) and Multi-Clean Concrete Preserver (bakelite-base) provide tough finishes that resist scuffing and wearing, that are not affected by water, grease, oils, or alkalis, and will not peel, chip, or fade with age. They'll give you an excellent base for wax, cut sweeping time and reduce the need for damp mopping.

For WOOD FLOORS ... The speed and ease with which your wood floors are kept in first-class condition with the *Multi-Clean Method* will reduce your maintenance costs. Even under heaviest foot traffic, your floors will retain their safe, glossy finish for longer periods between treatments. Ordinary dry sweeping will keep them clean, and periodic polishing with a Multi-Clean Floor Machine will remove the usual surface dirt and scuff marks, restoring brightness and lustre.



What is the MULTI-CLEAN METHOD?

The MULTI-CLEAN METHOD is a carefully planned and thoroughly tested procedure, developed by men who know floors and floor maintenance, for the most efficient and economical maintenance of floors. The Method specifies the use of proper materials and floor maintenance equipment with the correct applications for all types of floors and floor conditions.



Tested
finishes for
all types of
floors.



All-purpose
floor machine
mechanizes
maintenance.



High performance
wet-dry vac is fast
and efficient



FREE! GET THIS NEW
FLOOR MAINTENANCE
MANUAL!

Tells how to care for asphalt tile,
concrete, wood, terrazzo, rubber
tile, linoleum—easier floor main-
tenance at lower cost!

**MAIL
COUPON
TODAY!**

MULTI-CLEAN
PRODUCTS, INC.

Every Multi-Clean Product Carries a 100% Guarantee

MULTI-CLEAN PRODUCTS, INC.

2277 Ford Parkway, Dept. MH-3, St. Paul 1, Minn.

Please send me your FREE Maintenance Manual for all types of floors,
also information on equipment checked.

☐ 9-Job Floor Machine ☐ Wet-Dry Vacuum ☐ All-Purpose Scrubber

Name _____ Title _____

Address _____

City _____ Zone _____ State _____

(9-2)

What's New . . .

Cadillac Commercial Chassis

The 1952 Cadillac Golden Anniversary Models are designed to reflect Cadillac's adherence to high quality levels in the Commercial Chassis as well as in the passenger cars. The 190 horse-power V-8 engine, new hydromatic transmission and new rear axle are functionally balanced to give the greatest performance and highest fuel economy. The new models also feature wide selective performance range and versatility. Design engineering that permits even more effective use of the fuel-air mixture provides 20 per cent greater power output.

The "performance range" which locks out the fourth gear, brings a new driving range, especially adapted for ambulance use. A new low-speed downshift is provided with surging acceleration when desired. New brake features are also included as well as many other features of engineering that make the Cadillac Commercial Chassis outstanding for ambulance service. Cadillac Motor Car Division, General Motors Corp., Dept. MH, Detroit 32, Mich. (Key No. 878)

Wear-Ever Double Boilers

The new Wear-Ever Aluminum Alloy Double Boilers have two new features.

The inside containers are constructed of Alclad Aluminum, which consists of sheets of high purity aluminum permanently bonded to a core of high tensile



strength aluminum alloy, and the round inside containers will stand alone. The construction feature eliminates pitting through while providing a strong, dent resistant utensil. The new double boilers also have open sanitary beads, sanitary covers and seamless construction.

Heat spreads fast and evenly in the aluminum boilers and because of the conduction properties of aluminum, the double boilers may be used as cold servers by putting ice into the bottom

containers. The new utensils have loop handles, cool Bakelite knobs on the covers, strong construction and are available in 8, 12 and 20 quart sizes, inside container capacity. The Aluminum Cooking Utensil Co., Dept. MH, New Kensington, Pa. (Key No. 879)

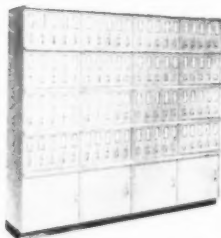
Insect Control Sprays

A new line of pyrethrin-synergist sprays for insect control is now being made available. Formulated especially for use with cold, mechanical, automatic microsol type dispensers, the sprays are the result of research with chemists, entomologists and independent testing laboratories. Experiments and tests to develop the sprays was followed by actual use tests in food establishments.

Pyrethrins with modern synergists provide safe and effective insect control without danger of food contamination. Results have proved to be instantaneous and complete with 50,000 feet of space effectively treated in eight minutes with a standard microsol unit. A smaller unit is available to treat 10,000 cubic feet in approximately five minutes. Dispensers for the new sprays are also available from the spray manufacturer. The Tanglefoot Co., Dept. MH, 318 Straight S. W., Grand Rapids, Mich. (Key No. 880)

(Continued on page 250)

IS YOUR PHARMACY EFFICIENT?



Top Units No. 20
Base Units No. 1

Grand Rapids-Schwartz
SECTIONAL SYSTEM

is as important to your hospital as is your operating room, or any of your other physical equipment.

NOW AVAILABLE FOR PROMPT SHIPMENT!!!

A booklet devoted entirely to Prescription Room equipment is yours for the asking.

GRAND RAPIDS STORE EQUIPMENT CO.

HOSPITAL PHARMACY DIVISION

GRAND RAPIDS 2, MICH.

FAST TRAY SERVICE

—Kitchen to ALL Floors



via OLSON Subveyor System

Economical Handling
of FOOD
and DISHES

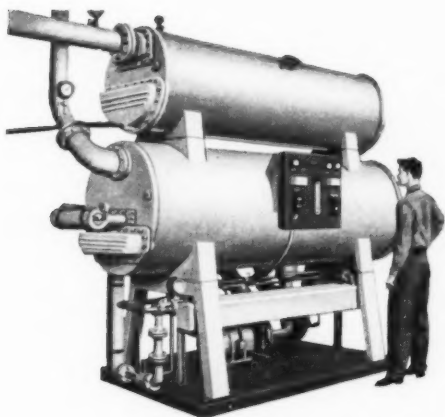


OLSON CONVEYORS
Since 1900

Speeds Feeding. Gets food to patients while hot and appetizing. Simplifies supervision by dietitians. Facilitates sanitation and sterilization. Saves space. Reduces handling labor. Avoids floor traffic and noise. OLSON Subveyor Systems also carry dishes from all floors to washer. Extensively used in Modern Hospitals. Send for Booklet today.

SAMUEL OLSON MFG. CO., INC.

2433 Bloomingdale Ave.—Chicago 47, Ill.



Who found work for idle steam at Self Memorial?

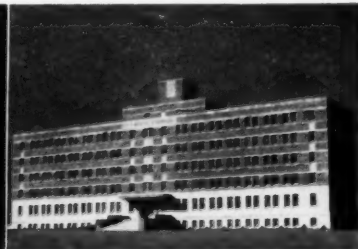
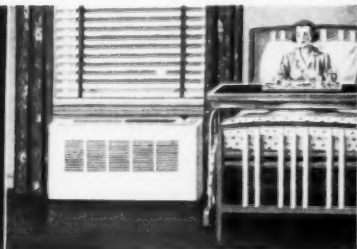
The Carrier Absorption Refrigerating Machine. Here's the story . . .

The new Self Memorial Hospital in Greenwood, S. C., is heated in the winter with steam from a boiler. During the summer months this boiler would normally be running at reduced capacity. Instead, it powers the Carrier Absorption Machine. And this machine uses otherwise idle boiler capacity to provide refrigeration for the air conditioning.

The Carrier Absorption Machine does more than balance winter and summer steam loads, of course. It gives you the advantages of an extremely lightweight, compact installation — suitable for roofs or intermediate floors without heavy foundations. It's practically vibrationless. Its refrigerant is the cheapest known — water. And its absorbent is safe — a simple salt. It handles partial loads automatically, has no major moving parts, needs no highly skilled personnel. It comes in five sizes, from 115 to 350 tons, adaptable for multi-unit installations. And its steam rate is less than 20 lbs. per hour per ton of refrigeration.

The whole story is in our folder, "Absorption Refrigerating Machines." Ask for a copy at the Carrier office nearest you, or write Carrier Corporation, Syracuse 1, New York . . . for 50 years—the people who know air conditioning best.

James C. Hemphill, architect; James Posey & Associates, consulting engineers.



A 200-ton Carrier Absorption Machine furnishes chilled water for 215 Conduit Weathermaster System room

units (similar to this one, left), as well as for other systems in the new Self Memorial Hospital (right)

**SLASH
MAINTENANCE
PAINTING
COSTS...**

**UP TO
40%**



**Enterprise
STAIZE-CLENE**
THE NEW MIRACLE DIRT REPELLING DISCOVERY

World's Only Paint Made With Patented **SYNCON***

*Made Under U. S. Patent No. 2,353,910

- Gives walls and ceilings 2 to 3 years of extra service—stays clean from 79% to 90% longer
- Lipstick, machine grease, mercurochrome and ink washes off without leaving a single trace of stain
- Calibrated colors — Da-Lite and Eye-Rest colors "rated" for light reflective values
- Complete line of Flat Enamel, Semi-Gloss Enamel and High-Gloss Enamel finishes — also Enamel Undercoater and Pigmented Primer Sealer

Compare the advantages STAIZE-CLENE gives you over any other paint. Weigh its dirt resistant qualities —note its better coverage—the fact that it goes farther —consider its high resistance to fumes—this will tell you why STAIZE-CLENE with Syncon has been hailed as the greatest improvement in paint in the last 20 years!

Send for the FREE STAIZE-CLENE Manual—"How You Can Reduce Your Maintenance Painting Cost," and learn how you can make substantial savings with this unbeatable maintenance finish.

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ENTERPRISE PAINT MFG. CO.

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Please send me the FREE Manual—"How You Can Reduce Your Maintenance Painting Cost."

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Firm _____

Address _____

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**It pays to buy
the VERY BEST**

**...to fight this
CONSTANT, COSTLY PEST...**

DIRTY FLOORS

Maintenance men know that labor and materials are the "big cost" items in the daily fight against DIRTY FLOORS. That's why the labor-saving, material-saving features of WHITE equipment are so important. Even if WHITE costs more (which it doesn't) — it would pay you to insist on WHITE efficiency in every piece of floor cleaning equipment you buy. See the complete WHITE line at your dealer's... see why you should buy WHITE.

WHITE MOP WRINGER CO.

9 Mahawk St., Fultonville, N.Y.



the janitor's friend

WHITE

'ROL OVL'

FLOOR CLEANING EQUIPMENT

Famous White Oval Bucket gives more room to wash the mop... Rol Ovl gives more pressure to wring it! 16- and 26-quart sizes, with gliders or rubber casters.

Write for CATALOG No. 150

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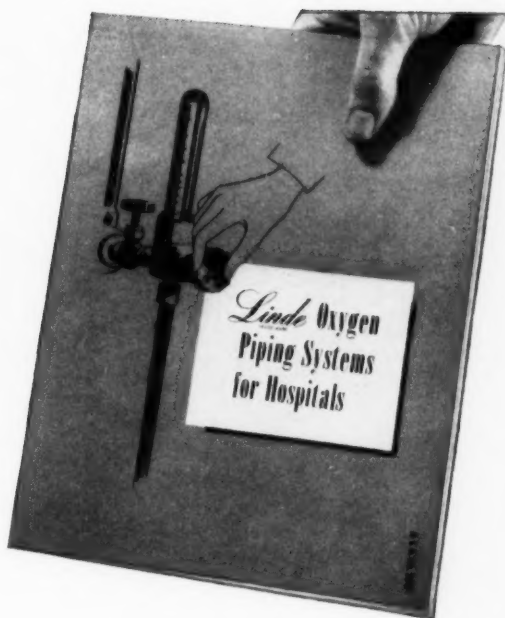
*It's RIGHT
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WHITE

A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

A method to help REDUCE your OXYGEN administration COSTS



"LINDE Oxygen Piping Systems For Hospitals", an illustrated 16 page booklet which presents the facts concisely, shows you HOW and WHY your hospital can save time and money with a modern oxygen piping system. In ten minutes reading time, you can get the full story about:

- ★ How hospitals and patients benefit.
- ★ Where and how to pipe oxygen for maximum benefit and economy.
- ★ Types of central oxygen storage systems, and how they operate.
- ★ What size system you will need.

With the help of this booklet, you can estimate the advantages of an oxygen piping distribution system for your existing building or for contemplated new structures. Send the coupon to LINDE for your free copy of this factual booklet.

In addition to the information contained in this booklet, LINDE engineers are prepared to give you the benefit of the experience accumulated in designing oxygen piping distribution systems for over thirty years.

Linde

Trade-Mark

The term "Linde" is a trade-mark of Union Carbide and Carbon Corporation.

In Canada: Write the Dominion Oxygen Company, Limited, Toronto.

Linde Air Products Company
A Division of Union Carbide and Carbon Corporation
Oxygen Therapy Department
30 E. 42nd Street, New York 17, N. Y.

Please send me a free copy of the booklet "LINDE Oxygen Piping Systems For Hospitals."

Name.....Title.....

Hospital.....

Address.....

What's New . . .

Electrically Conductive Sheeting

The new Archer electrically conductive waterproof sheeting has been developed especially for hospital use. The sheeting meets all electrically conductive requirements of the National Fire Protective Association, according to the manufacturer, and has passed all standard hospital use and cleaning tests. It is available for use either by itself or in pad assemblies. Sheeting No. EC-16 is a double coated black rubber sheeting and No. EC-12 is single coated black. Both are available in 12 and 25 yard rolls and have been developed to fill the need of hospitals for static proof operating room materials. The Archer Rubber Co., Dept. MH, Milford, Mass. (Key No. 881)

Photocopy Machine

A new machine has been developed to produce dry photocopies almost instantly. The Auto-Stat is based on a new principle of instant and automatic developing and fixing. No training or special skill is required to produce clear black and white copies of any original.

The new method is fast and simple, a finished copy being produced in less than thirty seconds. The unit is compact and occupies no more space than a

typewriter. It is extremely flexible with no limitations as to type of papers, documents or originals that can be copied, regardless of whether the original is printed on one or both sides or on



opaque or translucent paper. The unit is designed to handle letter and legal size copies as well as larger copies up to 11 by 17 inches. The machine is smartly styled and has a gray hammerloid and black wrinkle finish. It is sturdily constructed of stainless steel. American Photocopy Equipment Co., Dept. MH, 2849 N. Clark St., Chicago 14. (Key No. 882)

(Continued on page 254)

Electric Dehumidifier

The newly designed Fresh'nd-Aire Electric Dehumidifier has a new, streamlined appearance. Of more importance is the drawer type container at the bottom of the unit in which the water removed from the air is collected. When the drawer is full, it is easily slid from the bottom of the dehumidifier and emptied down the nearest drain. The unit stands less than 16 inches high, comes complete with carrying handle, and can be easily carried to any area where humidity is a problem. Fresh'nd-Aire Co., Dept. MH, 221 N. La Salle St., Chicago 1. (Key No. 883)

Liquid Skin Protector

Vanfaire Lotion is a new greaseless, non-sticky liquid protector for the skin. It dries quickly and leaves an invisible protective film which is resistant to all solvents except water. A potent non-toxic germicide in the lotion guards against infection from minor scratches and abrasions. Also included in the formula is an anti-histaminic to relieve or prevent allergic skin rashes. Vanfaire Lotion is supplied in gallon containers for Vanfaire Dispensers. Vanfaire Products, Dept. MH, 3757 Wilshire Blvd., Los Angeles 5, Calif. (Key No. 884)



Ask for Catalog #950.

(#1624 T TWIN TANK UNIT illustrated below.)



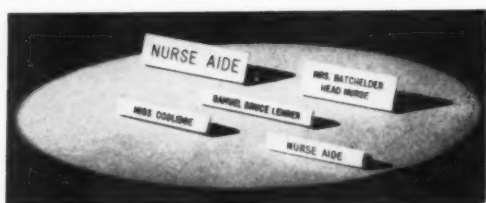
**Saves Time
Saves Work
Doubles Mop Life
No Splashing
Saves Cleaning Compounds
30% Lighter**

Acknowledged to be the most rapid acting wringer on the market, the famous downward-pressure GEERPRES flushes the water out of the mop uniformly and without splash. Elimination of pulling and twisting of mop gives longer mop life. All GEERPRES wringers are built for long service, with utmost strength and minimum weight. Fully guaranteed.

Also: Tangleproof mop sticks, mop buckets on casters, mopping trucks.

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Manufacturers of High Grade Mopping Equipment
P. O. Box 658 Muskegon, Mich.



IDENTIFICATION PINS

The actual width of our wider pins is three-fourths of an inch. The narrow pins are half that—three-eighths of an inch. The metal pin on the back of each has a safety clasp. The plastic part can be any desired length and color. Names are engraved, not printed. Regardless of length or width, any pin with one line of engraving is 60 cents, postpaid. With two lines of engraving, it is 90 cents. No discounts.

Our other specialties are name tapes, name-on bandage scissors, name-on laundry bags and inexpensive watches for nurses. We have 51 years of experience.

STERLING NAME TAPE COMPANY
STATION PLACE, WINSTED, CONN.



Amphitheater, Hartford Hospital, Hartford, Connecticut.
All other areas also Sound Conditioned with Acousti-Celotex.



Quiet . . . makes hearing easier in this hospital!

Poor acoustics, as well as unchecked noise, are a serious handicap in hospital amphitheatres. For poor acoustics interfere with distinct hearing. Cause students to strain for every word. As a result, tension and fatigue multiply, attention wanders, learning is sure to suffer.

The answer to this problem, scores of hospitals have found, is Acousti-Celotex Sound Conditioning. In amphitheatres and lecture halls, a sound-absorbing ceiling of Acousti-Celotex Tile improves acoustics, makes "front row" hearing possible for everyone. In lobbies, corridors, kitchens, rooms, nurseries and wards—it curbs unwanted noise, brings quiet comfort

that benefits patients and hospital personnel alike.

Acousti-Celotex Tile is quickly installed at moderate cost. Requires no special maintenance. Can be painted *repeatedly* and washed *repeatedly* without impairing its sound-absorbing efficiency.

GET A FREE ANALYSIS of the particular noise problem in your hospital without obligation. Write now for the name of your local distributor of Acousti-Celotex products. You will also receive free an informative booklet, "The Quiet Hospital." The Celotex Corporation, Dept. G-32, 120 S. LaSalle St., Chicago 3, Ill. In Canada, Dominion Sound Equipments, Ltd., Montreal, Quebec.

CAN BE WASHED REPEATEDLY—Two coats of tough finish, bonded under pressure of a hot knurling iron, build a surface of superior washability right into Celotex Cane Fibre Tile.



ACOUSTI-CELOTEX

Sound Conditioning

PRODUCTS FOR EVERY SOUND CONDITIONING PROBLEM

THE CELOTEX CORPORATION, 120 S. LA SALLE ST., CHICAGO 3, ILLINOIS

HERRICK

STAINLESS STEEL REFRIGERATORS

Performance-Proved

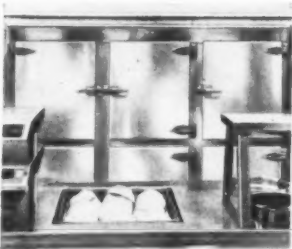
In the new cafeteria of

MINNESOTA MINING & MANUFACTURING COMPANY

St. Paul, Minnesota



Above: Partial view of service counter in new 3M Company Cafeteria showing one of the HERRICK RS566 Double-Front Pass-Through Stainless Steel Refrigerators installed there.



Left: A close-up view of another Stainless Steel HERRICK serving this modern cafeteria.

Herrick units were supplied by Joesting & Schilling Company, St. Paul.

In its new office building at St. Paul, Minnesota Mining and Manufacturing Company has provided a modern employee cafeteria. To keep foods served here at the peak of freshness and flavor, this famous maker of "Scotch" tape, "Scotchlite" reflective sheeting and "3M" abrasive and chemical products selected HERRICK Stainless Steel Refrigerators. • Two six-door double front pass-through HERRICKS and one four-door HERRICK supply just the right combination of chilling, air purification, circulation and humidity to prevent food spoilage, avert discoloration and reduce shrinkage. For beauty, performance and cleanliness, HERRICK Stainless Steel Refrigerators are unsurpassed. Write today for the name of nearest HERRICK supplier. Do it now!

HERRICK REFRIGERATOR CO., WATERLOO, IOWA
DEPT. M. COMMERCIAL REFRIGERATOR DIVISION

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The Aristocrat of Refrigerators

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*Send today to
Kenwood Mills
for complete
information, prices
and swatches on
hospital blankets.*



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Fund Raising Counsel

For a quarter century our campaigns have succeeded not only financially, but in the excellent public relations we have established for our clients.

Consultation without obligation or expense.

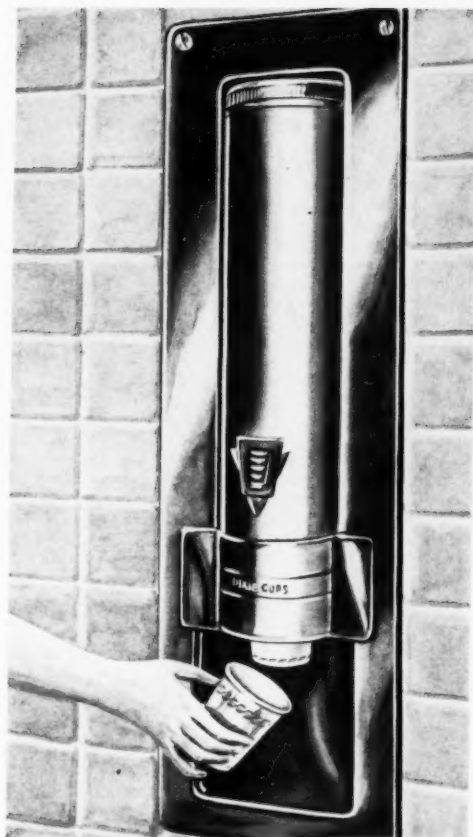
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provide plenty of water
and clean safe

DIXIE CUPS



Dixie Recessed Dispenser mounts flush in any wall—wood, metal, or masonry. Matches the finest appointments. Ideal for new buildings and those being remodeled.

Dixie Cups are the ideal water service for patients and staff alike. Dixies are used but once . . . are always clean and safe.

Dixie dispensers are available in a variety of kinds and sizes for every type of installation. They provide clean, dust-proof storage . . . yet keep Dixies right where they're needed . . . right at the fingertips.

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DIXIE CUP COMPANY

EASTON, PA., CHICAGO, ILL., DARLINGTON, S. C., FT. SMITH, ARK., BRAMPTON, CANADA

What's New . . .

Rubber Door Silencers

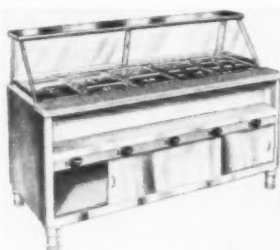
Noisy doors and drawers can be silenced with the new Pneumatic Rubber Silencers recently introduced. Two types are available: one for metal door frames and the other for wood door frames. Made of live, molded rubber, the silencers are installed on the vertical stop strip of the door, one near the top, one at the bottom and one above the latch. They are easily applied and inconspicuous since they are made in black and in white to harmonize with dark or light finish. In closing, the door compresses the rubber and forms an air pocket which gives added cushioning. The device cannot work loose and is tamper-proof.

The silencers prevent noisy slamming of doors, prevent latch rattle and can be used for desks, dressers, bedside tables and other furniture to silence closing drawers or cabinet doors. They can also be used on doors of transportation vehicles. **The Glynn-Johnson Corp., Dept. MH, 4422 N. Ravenswood Ave., Chicago 40. (Key No. 885)**

Hot Food Table

The new Seco-Matic Electric "Dry-or-Moist" Hot Food Tables have regulated, circulating heat for each separate top

opening. The unit is available in 68 heavy duty models, with two to seven top openings, for gas or electricity, with open, semi-enclosed or enclosed base.



Styles are available made of stainless steel, or of galvanized iron, all with stainless steel tops. Either dry or moist heat is provided simply by adding or removing small quantities of water and the units are constructed to operate without danger of burning out the concealed heating units.

The new Hot Food Tables are designed for easy cleaning with one piece die-stamped stainless steel top, eliminating crevices and cracks. The one piece die-stamped Seco-Matic heating receptacles have smooth rounded corners and are so designed that food cannot spill into the heating units. Individual dial settings for each independent sectional

(Continued on page 258)

top opening permits accurate, fast temperatures to reduce food waste. The units are insulated to assure even temperatures surrounding the containers and to prevent heat loss into the room. **Southern Equipment Co., Dept. MH, 5017 S. 38th St., St. Louis 16, Mo. (Key No. 886)**

Power Roof Exhauster

Operating noise is held to the lowest level with the new Gyra-Flo Power Exhausters recently introduced. Designed for roof ventilating applications in hospitals, schools and other institutions, the new exhausters have special suspension mountings and vibration control pads which eliminate magnetic hum and vibration. A special design gives the exhaust fan high efficiency and forces the air out into the atmosphere with a minimum of turbulence. This, plus low wheel tip speeds, keeps the noise level to a minimum. The fan wheel is welded heavy steel construction and the low symmetrical appearance of the unit blends with modern architectural design. The cover is removable for easy access and the housing can be furnished in aluminum, galvanized iron, copper, stainless steel or other special metals. **Chicago Blower Corp., Dept. MH, 9867 Pacific Ave., Franklin Park, Ill. (Key No. 887)**

Better Hot Foods for Institutions

Hot Liquids



VACUUM INSULATED

Hot Foods and Soup



AerVoid Vacuum Insulated HOT FOOD, SOUP AND COFFEE CARRIERS

Just transfer hot foods, soups, coffee from cooking kettles and coffee urns into AerVoid food and liquid carriers and the high VACUUM INSULATION of AerVoIDs will keep them hot for hours . . . transportable indoors or outdoors for servicing from a central kitchen. What a low-cost way to keep foods hot without continuous application of heat! Thousands in daily service amongst institutions, hospitals, industrial plants, schools, caterers and large Government and commercial feeding activities.

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Secret Process

FIREPROOF CHINA

CASSEROLES
BAKING DISHES
COFFEE POTS TEAPOTS
SERVING ITEMS • TABLE ITEMS
ROOM EQUIPMENT STEAM TABLE INSETS
STORAGE VESSELS MANY OTHER ITEMS

The only known cooking china made by our secret process that fuses body, glaze, and color inseparably. Craze-proof, stain-proof, absorption-proof... used in thousands of institutions.

THE HALL CHINA COMPANY
EAST LIVERPOOL, OHIO
World's Largest Maker of Fireproof Cooking China

NOW

A Different Dessert and Salad FOR DIABETICS EVERY DAY!



YOU KNOW how difficult it is to add variety to the menus of your patients on diabetic and reducing diets. That is why D-Zerta—the delicious saccharin-sweetened fruit-flavored gelatin—is such a wonderful discovery. For with D-Zerta, patients on low-calorie and low-carbohydrate diets can choose from more than 30 different desserts and salads. Your patients are provided recipes for all these dishes without charge.

D-Zerta is available in packages of 6 and 20 one-portion envelopes . . . directions and analysis of contents on each envelope.

D-ZERTA HAS THE SEAL OF ACCEPTANCE OF THE COUNCIL ON FOODS AND NUTRITION OF THE AMERICAN MEDICAL ASSOCIATION

COMES IN 6 DELICIOUS FLAVORS!

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Use this coupon for FREE professional sample and recipe book.

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Please send me a free professional sample of improved, sugar-free D-ZERTA.

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Offer expires February 28, 1953

The Amazing New Frigidaire Ice Cube Maker

Makes 5000 Solid Ice Cubes A Day For As Little As 26¢



Yes, now the remarkable new Frigidaire Ice Cube Maker solves a pressing refrigeration problem — the need for a continuous supply of pure, sanitary ice cubes at the lowest cost and with the least effort. This revolutionary new ice cube maker was designed and engineered by Frigidaire after an extensive survey of the needs of commercial users of ice cubes all over America.

It's completely automatic! No trays to fill or empty — nothing to turn on or off — no frequent cleaning. You don't lift a finger from the moment water flows in automatically until you scoop big,

perfect cubes out of the storage bin. What's more, the Ice Cube Maker is powered by the famous, dependable Frigidaire Meter-Miser compressor.

And every cube is uniform in size, crystal clear, completely clean. Solid all the way through — no holes! Drinks stay cool longer with less diluting — saves on mixes, too.

It'll pay for itself! Saving can amount to more than \$2 a day — nearly \$800 yearly. Save as much as 90% of the cost of purchased cubes. No melting losses or uncertain ice deliveries, either.




So compact 'n handy. Designed to fit under bars, counters, shelves — has flat, acid-resistant porcelain top that can be used for storage or for display area.



Frigidaire Ice Cube Maker

Over 400 Frigidaire refrigeration and air conditioning products — most complete line in the industry

 See your Frigidaire Dealer, find his name in the Yellow Pages of phone book. Or write Frigidaire Division of General Motors, Dayton 1, Ohio. In Canada, Leaside (Toronto 17), Ontario. Ask, too, for Frigidaire's Refrigeration Security Analysis of your needs and your refrigeration costs — no obligation.

"Televoice gives our doctors day-and-night records service

and look at these results!"

—reports Indianapolis Methodist Hospital

DOCTORS KEEP UP-TO-THE-MINUTE!

"Our physicians record as they practice--on the spot--thanks to EDISON TELEVOICE. They like it. It saves hours of their time," says the hospital's medical record librarian. No more tiresome, time-wasting longhand. Now doctors talk medical records from 22 TELEVOICE phones throughout the hospital at any time of the day or night. And all this without added hours for record room staff. Right: Reporting an operation minutes after it was performed.



BETTER RECORDS—TWICE AS DETAILED!

"The ease of TELEVOICE actually invites the doctor to report in full," states the record librarian. "And his records are more accurate--he doesn't have time to forget. TELEVOICE is clearer than handwriting. The result is perfect records, in type-written form." Left: Two typists, both blind, transcribe 25,000 words a day received on four TELE VOICE-WRITER recorders.

SAME-DAY TRANSCRIPTION!

EDISON TELEVOICE has eliminated peaks and valleys in record-handling at Indianapolis Methodist. Typewritten records are complete, always up-to-date and working for the patient's benefit! Left: Record librarian and medical record committee chairman discuss the vast improvement achieved with TELEVOICE. Their experience checks with that of other hospitals from coast to coast: EDISON TELEVOICE means better records, and better records mean better medicine!

DOCTORS LIKE AND USE TELEVOICE!

They find it as easy and natural as talking on the telephone: nothing to learn or get used to! (TELEVOICE is making news! Hospitals, November 1951, page 77, describes TELEVOICE in Wesley Memorial Hospital, Chicago; The Modern Hospital, November 1951, page 80, reports it at Indiana University Medical Center.)

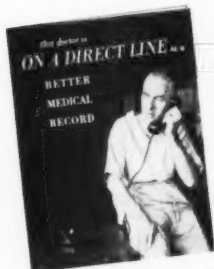
Only EDISON makes
TELEVOICE...the proved
Clinical Recording
System for better records

HOSPITAL ARCHITECTS, CONTRACTORS: See new and complete EDISON TELEVOICE catalog in the latest Sweet's Architectural File--Section 32.

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Here's the booklet that tells the whole story! It will be a revelation to you and your medical record librarian. Send for your copy of, "ON A DIRECT LINE TO A BETTER MEDICAL RECORD." Mail the coupon today!



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EDISON, 18 Lakeside Avenue, West Orange, N. J.

Please send me ON A DIRECT LINE TO A BETTER MEDICAL RECORD

NAME _____
TITLE _____
HOSPITAL _____
ADDRESS _____
CITY _____ ZONE _____ STATE _____

What's New . . .

Washable Wall Finish

A new wall finish, which is ready to apply and which the manufacturer guarantees to be washable, is being introduced under the name Quali-Kote. Formulated from newly-developed chemicals, Quali-Kote is designed for easy and constant maintenance, since in addition to its washability it is resistant to dirt, ink, grease and other substances. The finish is easily and quickly applied over any type of interior wall surface without the use of a primer or sealer and dries in approximately one hour. Quali-Kote is available in sixteen colors and white. The Sherwin-Williams Co., Dept. MH, 101 Prospect Ave. N. W., Cleveland 1, Ohio. (Key No. 888)

Non-Metallic Compartment

A new toilet compartment combining several non-metallic materials has been developed as a solution to one critical materials problem. Designed and engineered to embody all the structural features needed in a toilet compartment, it also satisfies sanitary requirements. Components consist of hardboard sheets cemented under pressure over solid insulation board with reinforcements for fittings and fastenings. Partition panels, pilasters and doors are flush type and

fabricated to dimensions that comply with the modular system of dimensional coordination. They are available in three different colors of finish that simulate the appearance of metal. The compartments are furnished complete with hardware and fittings ready for fast, easy assembly and installation. The Sany-metal Products Co., Inc., Dept. MH, 1705 Urbana Rd., Cleveland 12, Ohio. (Key No. 889)

Spirit Duplicator



Material from post card size to 8 1/2 by 11 inches can be printed on the new Master Portable Spirit Duplicator. As many as five colors may be printed at one time without the use of stencils, ink

or gelatin. The master can be prepared by typing or by writing with a ball point pen. As the machine is operated, the impression paper is moistened by rollers with a clear spirit which picks up carbon from the master.

The unit is compact and portable, weighing only 12 pounds, and is equipped with a case so that it can be carried conveniently. Operation is simple and easy and the duplicator is economical in cost. Master Addresser Co., Dept. MH, 6500 W. Lake St., Minneapolis 16, Minn. (Key No. 890)

Electric Stop Watch

The Lab-Chron electric stop watch is an especially designed counting unit with built-in reset mechanism and high torque synchronous motor. It is available in 1/10 second model reading to 9999.9 seconds and 1/100 minute model reading to 999.99 minutes. It was designed to function as a single unit, thus providing effortless operation for trouble-free performance. The stop watch has a case of heavy cast aluminum finished in metalized gray hammerloid. Four rubber feet prevent the Lab-Chron from sliding while in use and protect the table top. Laboratory Industries, Inc., Dept. MH, 4710 W. North Ave., Chicago 39. (Key No. 891)

(Continued on page 262)

It's the GENNETT ICE CART

MODEL XV
150 lb. capacity

GENNETT AND SONS, INC.
Richmond, Ind.

Right...the Model XV is the answer! Stainless Steel construction throughout, for DURABILITY.
Three-inch thick insulation keeps your profits from melting away.
Large pneumatic rubber-tired wheels, for ease of distribution.
Keep pace with the well-equipped hospital... *Go Gennett!*

ECONOMICAL • EFFICIENT • FEATHERWEIGHT



Victoria Thermal Pitchers

Keep hot things hot and cold things cold . . . for hours.

Easy on your hospital — easy on your nurses — easy on your patients.

Low initial cost, less breakage, easy to clean. Lightweight and one hand operated.

Colors: copper, pewter, gray, mahogany, or green, in non-toxic, odorless, tasteless plastic.

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Write to Dept. MH

VICTORY

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Hudson, Mass.

Victoria CREATIONS

The MODERN HOSPITAL

Ask
Your Heinz Man
How Heinz
Food Service Center
Can Help You



**Let HEINZ Staff Of Experienced Home Economists
 Help You Solve Tough Operating Problems**

NEED A DISH to dramatize as "Specialty of the House"? Tested ways to use leftovers tastefully? A means of making the most from plentiful foods? Let Heinz Food Service Center help you with these and other problems of quantity food service!

The Heinz Food Service Center is a fully staffed and equipped quantity kitchen. It is ready to give you *tested* answers to questions about menu planning, faster food service, work shortcuts, use of leftovers, cutting waste, etc.

Let your Heinz Man put this modern research center of quantity cookery and kitchen economics to work for *you*. It was established for your benefit, so feel free to take advantage of its many services.

Ask Your HEINZ Man About



HEINZ 57 VARIETIES

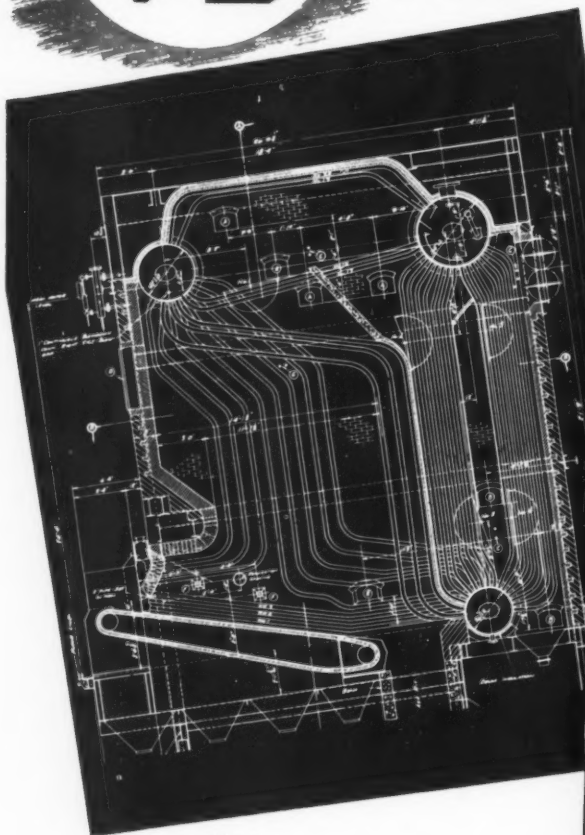
YOU KNOW THEY'RE GOOD BECAUSE THEY'RE HEINZ!

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Steam Generating Units

for **POWER**
or PROCESSING LOADS,
and **HEATING**

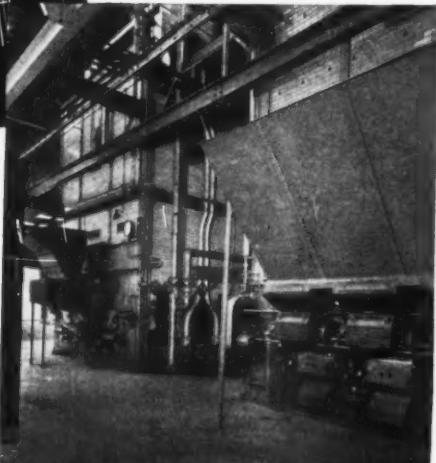


Above:
This 90,000 lbs. steam per hour unit,
designed for 475 lbs. pressure,
serves the Mansfield Tire & Rubber
Co., Mansfield, Ohio.

Vögt
FOR BETTER
BOILERS



Right:
Two 515 H.P. units installed in
Brown-Forman Distillers Corporation,
Louisville, Ky. Plant.



HENRY VOGT MACHINE CO. • 1000 W. Ormsby St., Louisville 10, Ky.
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just what the doctor ordered!

I like Lily® Cups and Containers. They're attractive, light and quiet.



Lily paper service saves me lots of work. I find the various kinds of Lily containers invaluable for medicines and supplementary nourishments. And so practical for contagious disease wards! For special diet cases name and room number are written on the snap-tight lids.



In the kitchens we pre-portion several foods in Lily Cups and Containers during slack periods. Many foods, from desserts to casseroles, can be moulded or baked... and served... right in the same Lily container! This saves washing loads of dishes and considerable breakage. We use various Lily Cups or Containers for water, milk, fruit juices, hot drinks, stews... even side dishes and salads.



Lily paper service deserves credit for substantial savings. And it's helped solve our labor problem, too. Lily provides the kind of efficiency that hospitals just can't afford to overlook.



Investigate the facts for your institution. Mail the coupon and we'll send samples and full information.

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Please send samples and full information on Lily Hospital Cups. MH-3

Name

Address

City Zone State

What's New . . .

Non-Pyrogenic Water Still

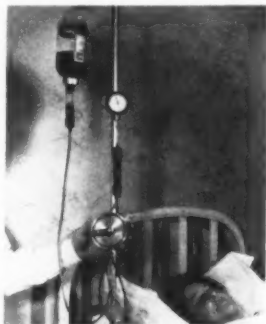
The NP Water Still has been especially designed with the needs of hospitals in mind. It is built to provide a sufficient quantity of non-pyrogenic water suitable for pharmaceutical use and for intravenous injection. It has been designed to counteract the hazards of back syphonage, osmotic pressure and other sources of impurities. The NP Impurity Discharger is the key factor in the still. It is also available as a separate unit for adaptation to fit any make, model or type of water still.

NP Water Stills are free standing, single distilling type, available with steam, gas or electric heating. Castings are of precision machined solid bronze with outside casing of polished stainless steel. William Barnstead Engineering Corp., Dept. MH, 39 Sudbury St., Boston 14, Mass. (Key No. 892)

Blood Pump

The Petri Blood Pump is a life-saving device designed to pump a pint of blood into veins or arteries within a minute and a half and under precisely controlled pressure conditions. Developed by Jan Petri, the device provides a means of pumping large quantities of blood, plasma or plasma substitute into patients

dying from loss of blood, as contrasted to the time required to give blood by the gravity method. It is particularly useful in emergency cases, both because of the rapid transfusion and because of



the simplicity of operation of the device, as well as in certain surgical conditions, burns, shock and hemorrhages.

The pump is small, approximately four inches in diameter and a half inch thick, is circular in shape and weighs less than a half pound. The tube from the blood bottle fits into a circular groove within the pump. The pump handle is turned for pressure, and the blood is forced through the tube at a rapid, controlled rate. The pump is designed for use with

disposable transfusion sets and does not have to be sterilized. A special counter can be attached to the pump to indicate the amount of blood or plasma administered. Blood can be given at any desired rate up to approximately 500 cubic centimeters in a minute and a half. American Optical Co., Dept. MH, Southbridge, Mass. (Key No. 893)

Plastic Liquid Containers

Several containers of polyethylene plastic are now available for preparation, storage and serving of liquids. The No. D-66 32 ounce juice container is 6 3/4 inches high with a 3 1/4 inch base diameter and a 4 1/4 inch top diameter. The No. D-68 50 ounce canister is 7 1/2 inches high. Both containers have tight fitting covers with pouring spouts to facilitate storage and serving. Liquids may be prepared either separately or in the containers and stored until ready to use. The contents are protected from spilling and can be served from containers.

Other items in the polyethylene line include unbreakable tumblers with or without tight fitting covers, bowls, spoons, dishes and other items which are light in weight, attractive in appearance and easy to use and clean. Dapol Plastics, Inc., Dept. MH, 90 Grove St., Worcester 5, Mass. (Key No. 894)

(Continued on page 266)

NipGard
DISPOSABLE
NIPPLE COVER

NipGard completely covers nipple and neck of nursing bottle. Instantly applied. Stays in place . . . does not jar off. No breakage. . . . Provides identification and formula data.

There is NO SUBSTITUTE
for SAFETY . . . INSIST ON
THE ORIGINAL . . . NipGard!

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PUBLICATION

NipGard Nipple Covers* are designed to meet modern health codes. Now used by many hospitals requiring terminal sterilization. Professional samples on request. Order through your hospital supply dealer.

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Stryker
AUTOPSY
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A new instrument which
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Electrically driven, oscillates at high speed to cut bone efficiently with complete safety. Cutting blades do not hurl material. Two-sided blade can be adjusted to three positions. Blade, arbor and shaft are stainless steel.

Dept. H

ORTHOPEDIC FRAME COMPANY Kalamazoo, Michigan



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Just what the doctor ordered

Pleasant surroundings have far more than casual value. Just as decorative colors and flowers encourage an optimistic frame of mind and convalescence, so does the attractive napery-covered tray. Patients look forward to tempting trays, welcome crisp fresh napery, a sparkling touch to the strictest diet.

Order SIMTEX Napery now and benefit your patients 3 ways:

- 1. AIDS APPETITES**—attractively served food is more appealing.
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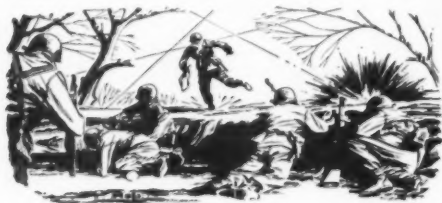
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DIVISION OF SIMMONS CO., MAKERS OF THE FAMOUS BEAUTYREST MATTRESS

Captain Raymond Harvey Medal of Honor



THE 17TH INFANTRY REGIMENT was attacking Hill 1232 near Taemi-Doug, Korea. Able and Baker Companies became split by a Red-held ridge. Charlie Company, Captain Harvey commanding, was moving up to fill the gap when the dug-in Red guns pinned it down. Calling for covering fire, Captain Harvey advanced



alone through a hail of enemy bullets. One by one, he personally wiped out four emplacements of machine guns and automatic weapons. Then he caught a bullet through the lung. But he stayed on, refusing evacuation, until sure the objective had been won.

"In Korea," says Captain Harvey, "we stopped aggression by united strength. You were helping—every time you bought a Defense Bond. Because your Defense Bonds were doing more than just helping keep you, and your family, and your country financially stable. They were backing us up in the field with American production power, the surest support any fighting man can have!"

"I hope you'll go on buying Bonds—many, many of them. For your Bonds—and our bayonets—are making America strong. And in today's cold-warring world, peace is only for the strong."

★ ★ ★

Remember that when you're buying bonds for national defense, you're also building a personal reserve of cash savings. Remember, too, that if you don't save regularly, you generally don't save at all. Money you take home usually is money spent. So sign up today in the Payroll Savings Plan where you work, or the Bond-A-Month Plan where you bank. For your country's security, and your own, buy U.S. Defense Bonds now!

**Peace is for the strong...
Buy U.S. Defense Bonds now!**



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How much TIME remains?



TIME . . . elapsed time . . . may spell the course of life . . . or the rush of death . . . Hands that race the seconds must be steady, reliable . . .

And the instrument for recording these seconds must be equally reliable. That is why Auth Elapsed Time Indicators are so frequently selected by leading hospital designers for use in operating rooms. They *are* reliable.

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What's New . . .

Pharmaceuticals

Acthar Gel

Acthar Gel is a long-acting ACTH preparation which facilitates and reduces the cost of ACTH therapy. Acthar Gel presents Acthar in a new repository form which parallels the development of repository forms of penicillin. In the majority of patients, a single injection of Acthar Gel is effective for 24 hours, replacing the four injections needed of the aqueous preparation at intervals of six hours. Acthar Gel is well tolerated locally and has proved satisfactory in extensive clinical investigations. It is available in potencies of 20 I.U. and 40 I.U. per cc. in 5 cc. multiple dose vials. Armour Laboratories, Dept. MH, 520 N. Michigan Ave., Chicago 11. (Key No. 895)

Pediatric Chloromycetin Palmitate

Pediatric Chloromycetin Palmitate has been developed especially for children too young to swallow capsules. This new custard-flavored form of Chloromycetin was recently discovered after hundreds of experiments and is now being put into production. It contains a tasteless derivative of the antibiotic and is supplied in a creamy liquid form which

does not require refrigeration. It is effective against many bacterial and rickettsial infections and has proved to be well tolerated by all age groups. Parke, Davis & Co., Dept. MH, Detroit 32, Mich. (Key No. 896)

Mi-Cebrin

Mi-Cebrin vitamin-mineral supplements, Lilly, supplies, in tablet form, ten appropriately selected minerals in addition to the eleven essential vitamins. It is indicated as a nutritional supplement in sustaining health, vigor and efficiency. Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 897)

Elkosin

Elkosin is a new sulfonamide for the treatment of urinary tract infections. It has low acetylation, high antibacterial potency and high solubility at wide pH ranges with great renal safety. It is bacteriostatic, even in small doses, and produces negligible side effects. It is especially effective in urinary infections due to two or more types of bacteria. Elkosin is supplied in scored 0.5 gram tablets in bottles of 100 and 1000. Ciba Pharmaceutical Products, Inc., Dept. MH, Summit, N.J. (Key No. 898)

Hydrocortone

Hydrocortone is now commercially available in limited quantities. This hydrocortisone acetate (Kendall's Compound F) is intended for use by the medical profession in direct treatment of the joints in rheumatoid arthritis and osteoarthritis. The new product is described as a close chemical relative to cortisone. Clinical trials have indicated that it is particularly useful when it is desirable to treat only one or a few arthritic joints. It may also be used as a supplement to maintenance therapy with Cortone in rheumatoid arthritis, for added relief in the most severely involved joints. Merck & Co., Inc., Dept. MH, Rahway, N. J. (Key No. 899)

Stenediol

Stenediol is now available in a higher-potency 10 cc. vial, each cc. containing 50 mg. of the tissue-building steroid. The new concentration is offered for added convenience and comfort of smaller volume injections and further increases the flexibility of dosage. Stenediol, a methyl androstenediol closely related to testosterone, has been widely employed to build tissue in cases not responsive to other therapy. Organon Inc., Dept. MH, Orange, N. J. (Key No. 900)

(Continued on page 268)

READY-POWER

AIR CONDITIONERS

OPERATE AT
LOWEST COST

Ready-Power Engine Refrigeration Units operate at a small fraction of the cost of electrically-driven equipment. Savings of \$50 to \$150 per month are often realized on single unit installations. Operate on NATURAL GAS, gasoline or Diesel fuel.

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Use them as medicine carts, dressing carts, utility carts for any portable equipment!

All stainless steel . . . sturdily built for years of service . . . easy to handle, easy to clean! Model 311 (shown) has three 15½" x 24" shelves . . . costs only 10c a day to pay for itself in a year. Other 3-shelf carts in standard and heavy duty models. Also 5 and 6-shelf tray trucks.

See Your Jobber or Write for Dealer's Name and Folder on Complete Line

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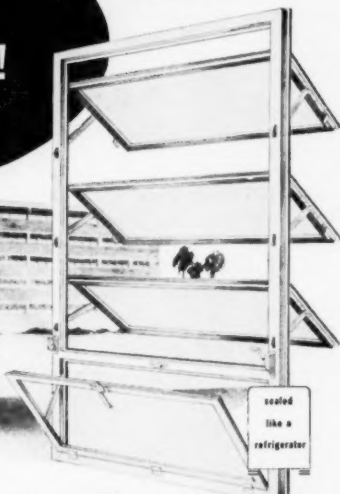
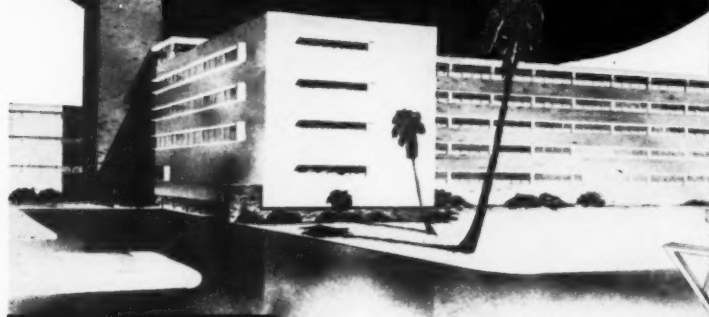
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THE HOSPITAL *Window* THAT NEEDS NO DOCTORING!

Shown below:
Addition to The Spohn Hospital
Corpus Christi, Texas
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Auto-Lok
PATENTED

Tightest Closing Window Ever Made!

Made for today's busy hospitals, because it needs so little care...so little "doctoring"...so little manual control! Requires only one hand operation by time-pressed nurses! No running to close windows when it rains...rain can't come in! It locks itself automatically...and seals itself shut like the door of a refrigerator!

IF YOU'RE PLANNING FOR AIR-CONDITIONING... think of the economy and efficiency of the *tightest closing window ever made!*

IF YOU'RE PLANNING FOR NATURAL VENTILATION... Auto-Lok Windows scoop in the slightest breezes...inward and upward...eliminate drafts!

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Perfectly-balanced, friction-free Auto-Lok Hardware requires no adjustments...ever! For the life of your hospital, your windows will continue to operate with "first-time" ease. They never stick, never rattle. They're easier to clean...all glass can be cleaned from the inside...top vent, too!

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Auto-Lok's tight closure cuts heating costs to a minimum. No cold spots around windows...air infiltration reduced to a degree heretofore believed impossible! Auto-Lok Windows provide perfect visibility, and fit readily into every architectural design.

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Auto-Lok
PATENTED

**AUTOMATIC LOCKING
ALUMINUM WINDOWS**
ALSO AVAILABLE IN WOOD

LUDMAN LEADS THE WORLD IN WINDOW ENGINEERING

What's New . . .

Bacillets

Bacillets are troches, each containing 20,000 units of penicillin G potassium and 50 units of bacitracin in a lime flavored, hard candy base. They are described as being bactericidal against most organisms encountered in infections of the oral cavity and are indicated in Vincent's disease and accompanying secondary infections, pharyngitis not accompanied by fever, prophylaxis before dental surgery and before and after tonsillectomy. They are supplied in bottles of 10 troches. **Abbott Laboratories, Dept. MH, North Chicago, Ill. (Key No. 901)**

Terramycin Vaginal

Terramycin is now being made available in vaginal suppository form, each suppository containing 100 mg. of terramycin. The new form is designed for the treatment of acute or chronic vaginitis due to organisms susceptible to the drug, for prophylaxis prior to vaginal surgery and for use following cauterization of the cervix. The product is supplied in cartons of ten, each suppository individually wrapped in aluminum foil. **Chas. Pfizer & Co., Inc., Dept. MH, 630 Flushing Ave., Brooklyn 6, N. Y. (Key No. 902)**

Mytolon

Mytolon Chloride Solution is a new synthetic compound for relaxing muscular spasm in surgery. It is administered intravenously with the anesthetic. Molecules of the drug blanket the receptor sites of all voluntary muscles, blocking nerve impulses and producing a relaxing effect which lasts from 15 to 20 minutes. It has also been found useful for muscular relaxation during electro-shock therapy. This new synthetic curare-like compound is supplied in vials of 10 cc., containing 3 mg. per cc. **Winthrop-Stearns Inc., Dept. MH, 1450 Broadway, New York 18. (Key No. 903)**

Dormison

Dormison, for simple insomnia where severe pain or agitated psychotic states do not co-exist, is a hypnotic, inducing calm, peaceful sleep. It is free from habit-forming properties, is rapidly metabolized, has no cumulative action and no toxic effects on prolonged use. Its active constituent is methylparafynol, a pure, highly volatile liquid. Dormison is available in soft gelatin capsules, 250 mg. each, in bottles of 100. **Schering Corporation, Dept. MH, Bloomfield, N. J. (Key No. 904)**

Diethylstilbestrol Dosage

The availability of Stilbetin 100 mg. Diethylstilbestrol Tablets has recently been announced. Stilbetin is a crystalline synthetic estrogen in tablet form, with suitable excipients. It is indicated for treatment where unusually high potency estrogens are needed. It is supplied in uncoated, scored tablets, in bottles of 50. **E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22. (Key No. 905)**

Elocaine

Elocaine is a non-oily, aqueous-miscible product for prolonged management of pain. It is an original development containing procaine and butyl amino-benzoate in stable solution at a critical saturation level. A single injection provides six to twelve days local anesthesia for postoperative control of pain in ano-rectal and abdominal surgery and minor surgery and for relief in pruritus ani and vulvae. The anesthetic depot formed by injection is slowly absorbed, assuring continuous local anesthesia, while the solvents are rapidly excreted. It is supplied in 20 cc. multiple-dose vials. **E. Fougera & Co., Inc., Dept. MH, 75 Varick St., New York 13. (Key No. 906)**

(Continued on page 270)



**Reduce
"breakage"
Costs**

Save with Restraware

**HEAVY DUTY
MELMAC**



Thousands of commercial or institutional restaurants, fountains and cafeterias have cut dinnerware costs in half through Restraware's long life. It's the proved and modern way to save money. Patrons and employees like it, too.

- *Light*
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All popular serving pieces designed for standard food portions and easy stacking. In smart permanent colors.

For money saving ideas and the name of your nearest supplier, write to

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NO HANDS

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FOOT POWER MARKER



Both hands are free to hold the coat, sheet or blanket in the exact position it is to be marked.

Works faster. Marks name, department, and date on one impression. Saves money, time and linens.



Applagate indelible ink . . . (silver base) is heat-set and lasts as long as the cloth on which it is used . . . Xanno is a long-lasting indelible ink (does not require heat). Either may be used with Applagate Markers, stencil or pen.

Write for Free Impression Slip.

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HERE'S HOW TO HAVE MORE ICE ...AT LESS COST!



One hospital found that stainless steel cabinets of 5 cu. ft. made compact, space-saving storage bins for their DER-2s.

Here's your answer to rising ice costs—the sensational, new, bantam-sized York-FlakIce Ice Maker DER-2.

Sized just right for diet kitchens and utility rooms, this newest and smallest York-FlakIce Ice Maker provides fast, on-the-floor ice service—at an operating cost less than the cost of ordinary ice. It pours out up to 300 lbs. daily of clear, clean ice that's faster cooling because of greater cooling surface. It eliminates hauling, handling, storing and crushing. There's no longer any need for frantic "S.O.S." calls to the main kitchen for more ice. The staff on each floor can get all the ice needed for packs, beverages, and delicacies—when it's needed. Automatic "no hands" operation assures you ice that's purer than the water from which it was made.

Despite its smaller size, the DER-2 contains all the features of economy and efficiency that characterize the entire line of York Ice Makers—that have made them more popular than all other makes of "packaged" ice makers combined.

If you want to cut ice costs and still improve your ice service, consult your nearby York Representative (listed in your Classified Directory) or write York Corporation, York, Pennsylvania.



DER-2 FEATURES

Completely Hermetically Sealed
Refrigeration Circuit.
Famous York Compressor.
Rotating Stainless Steel
Freezing Drum.
Stainless Steel Cutter
and Collector Blade.
Sanitary Ice Chute.
Baked Enamel Hammerstone
Gray Jacket.
Underwriters' Laboratory
Sanitary Codes approval.
Only 24" in Diameter and 32" Tall.
Continuous Operation.



The big advances come from

YORK

Headquarters for—Refrigeration and Air Conditioning

What's New . . .

Product Literature

• Savings can be effected in fuel consumption, and efficiency of the heating system can be increased through the restoration process described in a brochure issued by Chas. J. Riley & Sons, 6352 N. Maplewood Ave., Chicago 45. What causes the drop in heating efficiency of a heating plant and how it can be corrected are discussed in the brochure. A second maintenance problem covered is the water storage tank. How it can give far longer service when protected against rusting and pitting by **Rock-Tite Stone linings** is brought out in the text. (Key No. 907)

• A new folder which shows the role of **AerVoID containers in Disaster Relief** has been issued by the Vacuum Can Co., 19 S. Hoyne Ave., Chicago 12. It suggests a solution of the problems of emergency mass feeding and cautions, "To wait until a bomb falls is too late. The required equipment for a civil defense feeding set-up must be on hand . . . ready for use if and when disaster hits." (Key No. 908)

• "Tomorrow Is Today" is the title of a brochure recently released by the Brown Instrument Division, Minneapolis-Honeywell Regulator Co., Wayne & Windrim Aves., Philadelphia 44, Pa.

Those concerned with research will find much helpful and informative data in this booklet on new and improved instruments and their importance in research and industry. (Key No. 909)

• A new illustrated catalog of **Vitalium Surgical Appliances** is now available from Austenal Laboratories, Inc., 224 E. 39th St., New York 16. The attractive catalog illustrates both the surgical appliances and the surgical instruments and gives detailed technical advice regarding the products. Printed in black and red, the catalog illustrates many of the uses to which these Vitalium appliances can be put. (Key No. 910)

• Descriptive information and specifications on the **Tornado Model 230 Noiseless Vacuum Cleaner** are given in a folder issued by Breuer Electric Mfg. Co., 5124 N. Ravenswood Ave., Chicago 40. Photographs illustrate the various uses to which this unit can be put in an institution and the building maintenance and rug and upholstery attachments are illustrated and described. (Key No. 911)

• The lines of air cooled and radiator cooled and marine water cooled **electric generating plants** manufactured by Universal Motor Co., Oshkosh, Wis., are listed and priced on Form SE-3 now available. (Key No. 912)

• **Barnstead's Water Demineralizer for Laboratories** is described in **Bulletin No. 124** recently released by Barnstead Still & Sterilizer Co., 124 Lanesville Terrace, Forest Hills, Boston 31, Mass. The demineralizer connects directly to any water supply and delivers the demineralized water in continuous flow. Its seven new features, including the new direct reading type meter, are fully covered in the new bulletin. (Key No. 913)

• How punched-card users can speed-up and simplify the preparation of records and reports is discussed in a new 18 page illustrated folder issued by Remington Rand Inc., 315 Fourth Ave., New York 10. Detailed information is given on the **Remington Rand Interfiling Reproducing Punch** and the time and money saving which can be effected by its use. (Key No. 914)

• Technical and practical information on the **Nefluoro-Photometer** is given in a new booklet released by Fisher Scientific Co., 717 Forbes St., Pittsburgh 19, Pa. Described as three precision instruments in one designed to grow with your laboratory, the Nefluoro-Photometer is a new electronic instrument making possible the rapid determination of a great variety of materials, organic and inorganic, synthetic and biological. (Key No. 915)

(Continued on page 272)

SOUND LECTERN



A complete SOUND SYSTEM built into a beautiful walnut LECTERN. Used by leading hospitals for doctors conferences, instruction, meetings, lectures. MOVE IT ANYWHERE — PLUG IN POWER CORD AND IT IS READY FOR USE. Built-in loudspeaker will handle audience of 500. Desk and lapel microphones furnished. External speakers, recorder and phonograph may be added. Practical reading desk and light. Built by the company who furnished all the sound for United Nations at Lake Success.

Write for Booklet No. 101

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SURGEONS' NEEDLES
MADE IN ENGLAND
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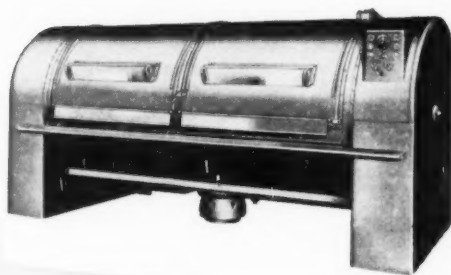
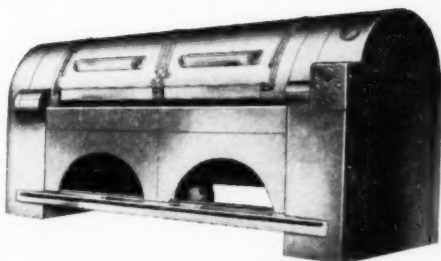
**FOR HIGHER
PRODUCTION
PER SQUARE FOOT**

**FOR LOWER
COST PER
POUND PROCESSED**

Hoffman Monel Metal "Unloading" and "Standard" Washers

THE "UNLOADING"

Provides more rounds per day by cutting down time formerly needed to "pull" loads. Hydraulic mechanism raises cylinder and shell. Work is deposited into trucks or into basket halves of an unloading extractor. Releases labor for other operations and avoids wear and tear on loads. Single-end drive. Monel metal construction.



THE "STANDARD"

Furnished with open-pocket or horizontal partition. Latter type facilitates "No-Lift" unloading since horizontal partition lines up level with shell door opening. All standard cylinder sizes. Monel metal construction.

YOUR CHOICE OF WASH CYCLE CONTROLS available on "Unloading" and "Standard" Washers. Fully automatic, with central or individual supply stands. Or, semi-automatic with air-actuated control of each operation, once supplies are added.

Modernize Now! Ask your Hoffman Representative About Our Complete Line of Laundry Equipment



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What's New ...

Methods Manuals

A practical discussion of the importance of proper chemical laboratory fume hood installation is presented in a booklet, "Handle With Care All Laboratory Fume Removal Problems," recently issued by E. H. Sheldon Equipment Co., Muskegon, Mich. The carefully presented text is supplemented by drawings which illustrate the points made. Sheldon equipment designed to help solve this problem practically is mentioned. (Key No. 916)

"The Theory of the Microscope" is the title of a new booklet issued by Bausch & Lomb Optical Co., Dept. FF-1, Rochester 2, N.Y. Written by James R. Benford, head of the Microscope and

Telescope Department of the company, the book presents a non-mathematical exposition of how a microscope works, with some notes on conditions which influence optical performance. Objectives, eyepieces, condensers, filters and types of illumination are treated in a non-technical manner and the text is illustrated with photographs and drawings. (Key No. 917)

• A recommended Fire Resistance Test for Asphalt Tile has recently been released by the Asphalt Tile Institute, 101 Park Ave., New York 17. The test was perfected by the Technical Research Committee of the Institute and is available from its offices. The test indicates that asphalt tile is one of the safest floorings from a fire prevention standpoint. (Key No. 918)

"Your Floors and How to Maintain Them" is the title of a new booklet recently published by Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 1, Minn. Divided into sections, the 40 page manual gives general information on the importance of proper floor maintenance and then covers the care of asphalt tile, concrete flooring, terrazzo, rubber tile, wood and linoleum, and has a section on shampooing carpets and rugs. Multi-Clean equipment and supply items for floor maintenance are also described. (Key No. 919)

Book Announcements

Anson and Maddock, "Callander's Surgical Anatomy," 3rd ed., 1074 pp., \$14. Hansen, "A Review of Nursing, With Outlines of Subjects: Questions and Answers," 7th ed., 844 pp., \$5.75. Wright and Montag, "Drugs and Solutions," 91 pp., \$1.75. W. B. Saunders Co., Dept. MH, Philadelphia 5, Pa. (Key No. 920)

Miller, "Textbook of Clinical Pathology," 4th ed., 1077 pp., \$9. The Williams & Wilkins Co., Dept. MH, Mt. Royal & Guilford Aves., Baltimore 2, Md. (Key No. 921)

Suppliers' News

Frederic Blank Co., Inc., 230 Park Ave., New York 17, manufacturer of washable and fadeless wall coverings, announces the appointment of A. B. Boyd Co., 1235 Howard St., San Francisco 3, Calif., as its West Coast and mountain states sales representative. The Boyd organization has branch offices in principal West Coast cities. The company also announces the appointment of Edwin C. Boyette & Son, Inc., 216 E. Morehead St., Charlotte, N. C., as sales representatives for North and South Carolina.

Edward Don & Co., 2201 S. La Salle St., Chicago 16, distributors of institutional furnishings and food service equipment and supplies, announces the acquisition of the physical assets, general lines and good will of The Perlman Company, Chicago, distributors of fine glassware and china for seventy-five years.

H. J. Heinz Co., Pittsburgh, Pa., manufacturer of food products, announces the opening of its new modern Vinegar Building which is now producing Heinz White, Cider, Malt and Tarragon Vinegars.

Vulcan Hart Mfg. Co., Inc., 2006 Northwest Pkwy., Louisville 3, Ky., manufacturer of cooking equipment, announces the acquisition of the line of steam-jacketed kettles, meat roasters, coffee urns and milk pasteurizers manufactured by Royce L. Parker Inc., Addison, Ill.

THIS COUPON is provided for your convenience in requesting additional information.

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